

University of Warwick institutional repository: <http://go.warwick.ac.uk/wrap>

A Thesis Submitted for the Degree of PhD at the University of Warwick

<http://go.warwick.ac.uk/wrap/50831>

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it. Our policy information is available from the repository home page.

Health Beliefs and Help-Seeking Practices of Migrants from the former USSR into Germany

A thesis submitted in fulfillment of the
requirements for the degree of Doctor of
Philosophy in Sociology

Polina Aronson

University of Warwick, Department of Sociology, September 2011



TEXT BOUND INTO

THE SPINE

Table of Contents

List of Figures	5
List of Tables	6
Acknowledgements	7
Research Abstract	8
Introduction	9
Chapter 1. Literature Review	15
1.1 Homo Sovieticus: A Disempowered Fatalist or a Struggling Help-Seeker?	20
1.2 Homo Sovieticus Meets Enlightened Westerner: A Soviet Person Abroad. Reviewing Existing Knowledge and Conceptualising an Approach to Health.	32
Summary	41
Chapter 2. Research Methodology	42
2.1 Research Design	44
2.2 Research methods: semi-structured lay and expert interviews	48
2.1.1 Lay interviews (N = 27)	48
2.1.2 Expert interviews (N = 8)	50
2.3 Sampling and recruitment strategy. Aspects of fieldwork.	52
2.4 Lost in translation? Reflecting on cross-lingual and cross-cultural research setting	59
2.5 Ethical considerations	63
Chapter 3. Migratory processes to Berlin. Charlottenburg and Marzahn: The Emerge and Structure of ‚Russian‘ Neighbourhoods	65
3.1 Charlottenburg	67
3.1.1 Migratory processes to Charlottenburg	71
3.2 Marzahn	77
3.2.1 Migratory processes to Marzahn	80

Summary	85
Chapter 4. Genealogy of health beliefs. SES gradient and Identities: Experience in the Sending Country	87
4.1 The Disadvantaged: Rural Russian Germans	91
4.2 Fragmentarily Empowered: Urban Russian Germans	99
4.3 The Privileged: Self-Funded and institutionally-funded Jews	104
Summary	113
Chapter 5. Migration, Socio-Economic Mobility and Transformation of Identities. Effect on Health Beliefs and Help-Seeking Behaviours	115
5.1 Socio-economic mobility in the receiving country	116
5.2 Identities and Boundaries	122
5.2.1 Transformation of kul'turnost: Westernizing individual behaviour	126
5.2.2 Diligence and family ties: Preserving the tradition	138
5.2.3 Cross-boundary similarities: gender roles	146
Summary	148
Chapter 6. Transition to the world of plenty	150
6.1 Natural environment. The Air We Breathe	154
6.2 Housing. Hot Water 24/7	158
6.3 Nutrition. The plethora of (plastic) tomatoes	163
6.3.1 Eating like a Westerner. Anti-Soviet Food	169
Eating salad	169
Shopping for bio	171
Summary	180
Chapter 7. Juggling the Choice: Seeking Help from Outpatient Services	182
7.1 Reflecting on ethics and the logic of choice	185
7.2 Drowning persons should rescue themselves by their own means	187
7.3 Endorsing the liberty: Shrugging off the socialist past	197

7.3.1 No Russian doctors, please!	200
7.3.2 Reliance on Heilpraktiker	203
Summary	207
Chapter 8. Following the Tradition. Satisfaction with Care: Hospitalisation and Nursing Care	208
8.1.1 Giving birth	214
8.5 Nursing Care	220
Summary	229
Conclusions	230
Retrospective analysis. Establishing the core concepts: Kul'turnost and takaya zhishn	232
Migratory process and transformation of health beliefs and help-seeking behaviors. Westernization and transition into the world of plenty.	234
Contribution to existing debate. Prospects for further research. Policy implications.	239
Bibliography	244
Appendix 1. List of Interview Participants	255
Appendix 2. Glossary	267

List of Figures

Figure 1: The location of Charlottenburg and Marzahn in Berlin.....46

Figure 2. Marzahn.....46

Figure 3. Charlottenburg.....47

Figure 4. 'Rossiya' shop at the Charlottenburg main S-Bahn station.....67

Figure 5. Areas of dense Jewish settlement in the USSR, 1945-1991.....75

Figure 6: Repatriation of Ethnic Germans from the USSR, 1950-2005.....81

Figure 7: Repatriation of Ethnic Germans from the USSR, 1986-2000.....82

Figure 8: Areas of dense Russian German settlement in the USSR, 1945-1991.....84

List of Tables

Table 1. Structure of the matching sample.....53

Acknowledgements

My most sincere gratitude goes to my PhD supervisors Hannah Bradby and Simon Clarke, who have guided me through the research process, always ready to give advice, never failing to support, and, when necessary, being critical and skeptical. Their engagement and attention have greatly motivated me in these four years as a PhD student. Their capacity of questioning what seems obvious is the greatest lesson I hope I learnt from them.

I am also very grateful to colleagues in St. Petersburg who have carried out fieldwork in Russia, studying health beliefs and help-seeking practices of the post-Soviet society. Nina Rusinova at the Institute of Sociology at Russian Academy of Sciences, Anna Temkina and Elena Zdravomyslova at the European University kept inspiring me with useful insights and important criticisms on relationship between social difference and health.

Discussions with German scholars stimulated my understanding of ways difference, ethnicity and health are approached in their tradition. I am very grateful to Susanne Kümpers and Katrin Falk (Wissenschaftliches Zentrum Berlin), Josephine Heusinger (Institut für Gerontologische Forschung), and Liane Schenk (Institut für Medizinische Soziologie Charite).

I am most grateful to all persons who took part in the interviews, and to those who helped me to find research participants. Alexander Reiser and Hans Birnbaum (Aussiedler helfen Aussiedler), Olga Günther (Quartiersmanagement Marzahn), Sergei Lagodinsky and Liliane Lieberman (Jewish Community House) provided their kind help and support throughout fieldwork.

Finally, I would like to thank my PhD colleagues, friends and family for the support and inspiration they have been giving me. Milena Kremakova (Warwick University), Edit Szenassy (Charles University Prague) and Stephen Cave (Financial Times) have been giving their useful comments and motivating me. My husband never failed to take time off his own PhD thesis in order to discuss mine, my mother made me finish what I started, and, finally, my grandmother, who carried out thermodynamic experiments in post-siege Leningrad, made my own research endeavor seem like a pleasant entertainment.

Research Abstract

Persons from the former USSR constitute a significant proportion of the migrant population in contemporary Germany. Current research on their health is scarce and carried out from a medical perspective, mostly focusing on health outcomes and patterns of healthcare utilisation. In contrast, this thesis is based on a sociological approach to health as a phenomenon embedded in a complex system of social stratification and cultural traditions. The research question of this thesis is about the relationship of identity to health beliefs and help-seeking practices, and the ways migration transforms ways people think of themselves and their health. To answer this question, qualitative research needs to establish migrants' own interpretations of health and illness in the biographical context.

Setting out to identify and explain a variety of native conceptualisations of health, this thesis, on the one hand, seeks to establish differences between migrant and non-migrant population, and, on the other hand, to reflect on heterogeneity of health beliefs and help-seeking behaviours across different sub-groups of former Soviet citizens in Germany.

In order to pursue these research objectives, comparative qualitative research design was employed, whereby different groups of migrant population were compared with each other and contrasted to native Germans. The empirical fieldwork was carried out in Berlin in 2009-2010, and included 35 semi-structured interviews (of which 8 were carried out with experts).

This thesis suggests that health beliefs and help-seeking practices of migrants from the former USSR in Germany are highly heterogeneous. Attitudes to health make up components of diverse identities acquired in the sending country and that are transformed throughout the migratory processes. First, these findings argue against generalisations about 'fatalistic' health beliefs resulting from communist ideology, a stereotype appearing in some Western literatures. Second, this thesis draws attention to the effects of socialisation in the sending country on conceptualisations of health in the country of immigration, suggesting prospects for research in future migrant generations. And third, it demonstrates that folk conceptualisations of health are hugely heterogeneous, and diverge greatly from medical views of health as an absence of illness.

Introduction

This thesis sets out to explore and conceptualise the health beliefs and help-seeking behaviours of persons from the former USSR in Germany. This focus is guided by several considerations. First, it offers an insight into the ways that socio-economic and cultural transitions affect how people think about health. Second, it should contribute to the understanding of socialist cultures of health in transition. Third, a focus on persons from the former USSR addresses a gap in existing knowledge on Germany's immigrant populations.

Throughout the 20th century, several million people from the former USSR have migrated to Germany, making up a significant proportion of its current migrant population. Starting immediately after the Bolshevik Revolution, coming to a halt up during the Khrushchev Thaw years and increasing dramatically after the collapse of the USSR, the immigration included persons of various cultural and socio-economic backgrounds, from former Tsarist aristocracy to *kolkhoz* peasants.

The most significant migration wave occurred after the collapse of the Soviet Union, with Germany becoming a new home for more than three million people from the former Soviet republics. The greatest proportion of these latest migrants, that is, more than 2.5 million persons, is constituted by *Spätaussiedler* or *Aussiedler* members of Russian German ethnic minority (Dietz 1995; Dietz 1999). In accordance with the German constitution, these persons were accepted into the country as members of the German folk, formally being 'repatriated' into their 'Motherland'. Another significant group of migrants, about half a million persons, is constituted of *Kontingentflüchtlinge* or Soviet Jews, who were accepted to Germany as asylum seekers, supposedly fleeing (post) Soviet anti-Semitism (Schoeps 1996; Schoeps 1999), expected to join the declining German Jewish communities. In both cases formal ethnic status served as the main criterion for acceptance into the country. Both categories of migrants were granted German citizenship and social benefits almost upon arrival, which made them greatly privileged in comparison to preceding generations of former guest workers from other countries who have settled in Germany since the 1960s. Along with those two ethnic minority groups recruited by means of *institutionalised* acceptance programs, Germany has received a significant number of *self-funded* migrants from the former USSR republics, who have come into the country for a variety of reasons and remained under a variety of

legal statuses including illegally. The complexity of these migratory processes has created a highly heterogeneous migrant population: groups of migrants are distinct in their ethnic descent, socio-economic backgrounds, acceptance statuses, family types, connections to the sending country and other characteristics.

The case of migrants from the former USSR in Germany provides with a new angle on studying socialism as a distinct culture (rather than a political or an economic system), with health beliefs and help-seeking behaviours as specific components. Indeed, after the collapse of the USSR, sociologists and epidemiologists started paying increasing attention to attitudes to health in the former socialist block. To a great extent, this interest was caused by the mortality and morbidity crisis that Russia and other ex-Soviet republics have experienced. As I will demonstrate in the literature review, a significant body of literature discusses 'fatalistic', 'poorly informed', 'paternalism-driven' behaviours of the (former) Soviets towards their health as one of the main reasons behind increased morbidity rates for specific conditions and reduced life expectancy for particular demographic groups in the 1990s. The problem with this view is that it tends to neglect the material effects of post-Soviet poverty, and over-stresses the role of socialist ideology in formation of health beliefs and help-seeking tactics; it depicts Soviet people as profoundly different from Westerners, an approach summarised by Annemarie Mol as follows:

The difference between autonomy and heteronomy has come to mark the difference between 'the West' and 'the Others'. In this context the West is typecast as a place/time where people make individual choices, while 'the Others' are said to be embedded in their communities. While God, tradition and the collective give meaning and coherence to 'their' lives, 'we Westerns' are supposed by contrast to have been free of such restrictive ties since the Enlightenment. (Mol 2008: 3)

Another body of research contests this view as an overgeneralisation and suggests strongly that in common with other developed societies, the former USSR was characterised by a variety of health cultures, resulting from socio-economic difference and cultural heritage (Rusinova and Brown 2003, Rivkin-Fish 2005, Lindquist 2002, 2006). These studies demonstrate that attitudes to health across the Soviet population varied greatly, played a role in constituting people's identities, and suggest that a differential approach is necessary to understand attitudes to health in (post) Soviet society.

The case studied in this thesis permits a further development of this discussion by studying how health beliefs of persons from the former USSR transform through the

process of migrating to a capitalist society. I will explore differences in attitudes to health observed in various groups of migrants and will conceptualise their socio-economic and cultural determinants. I will look at how persons from different segments of the Soviet society conceptualise the effects of migration on their health, and will follow their patterns of help-seeking in the new society. I will demonstrate that migrants, who have been socialised under different conditions in their sending country, develop different ideas about health and help-seeking throughout migratory process.

Research into migrant and ethnic minority populations in Germany has been developing within the general political discourse on migration, with culture, nationality and ethnicity often used in policy making as interchangeable concepts. In that context migrants from the former USSR were initially treated as distinct ethnic groups, and their identities were understood in terms of belonging to homogenous ethnic cultures (Dietz 1995, Shoeps 1996). This approach was based on German 'repatriation' and 'asylum seeking' policies, which made migration from ex-USSR almost exclusively limited to people with a documental proof of Russian German or Jewish ethnic ancestry (as discussed in Chapter 1). Transplanted into social research this approach, on the one hand, tended to impose formal or altogether artificial ethnic categories on groups of people which may not feel connected to each other in a meaningful way, and, on the other hand may neglect socio-economic conditions of migratory processes. As a result, such research focused on deviation from what it considers to be 'real' Russian German or Jewish (early studies by Dietz and Schoeps cited above may provide with examples of such approach). Later studies, undertaken from perspectives of qualitative sociology, social anthropology and oral history, offer a deeper insight into lives of Jewish and Russian immigrants in Germany (Doomernik 1997, Hegner 2008, Wierling 2004). First, they suggest that migrants' identities are very heterogeneous and contextual, whereby being 'Russian German' or 'Jewish' may be interpreted in a variety of ways. Second, they demonstrate significant socio-economic variations in group of migrants with the same formal ethnic status. Contested identities and intricate socio-economic transitions of migratory process make up an important theme of the 'Russian' immigrant literature in Germany, as well (Kaminer 2002, Gorelik 2006).

Although migrants from the former USSR have been studied from different perspectives, literature on their health is rather limited to medical perspective, whereby illness patterns and participation in healthcare services were analysed (as will be discussed in Chapter 1). These studies offer interesting and well-researched insights into

health outcomes and healthcare utilisation patterns, however, with respect to sociology of health, they leave important knowledge gaps, which this thesis will set out to respond to.

First, there is a need to complement existing epidemiological research with sociological understanding of health as a phenomenon embedded in socio-economic and cultural context. Although issues related to unemployment, deteriorating family structures and perceived stigmatisation have been documented in ex-Soviet immigrant population (Dietz 1995; Schoeps 1996; Doomernik 1997; Becker 2001; Damelang 2011), sociological conceptualisation of their effects on health has not been outlined yet. Partially, this lack of sociological research into health of migrants from the former USSR results from traditionally strong focus of German medical sociology on a different group of migrants, the former Turkish *Gastarbeiter* (see, for example, David and Borde 2002, David 2000, David 2006). Indeed, Turkish migrants and their descendants experience significant difficulties achieving upward social mobility and often feel discriminated against, thus, the focus on their problems has important reasons (Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration 2010). Categorised as Muslims and cast against to the supposedly Christian German society, Turks are regarded as difficult to integrate into local healthcare system, and, hence, are given attention as a problematic case. ‚Russians‘, instead, are likely to be perceived by the receiving society as not ‚different‘ enough to be studied from a variety of perspectives. Similar problems of neglect have been observed by Hickman, Novak and Staniewicz (Novak 1996; Hickman 1998; Staniewicz 2001; Walter, Hickman et al. 2002) with respect to other white Judo-Christian ethnic minorities in different developed countries.

Second, sociological perspective on health calls for an approach, differentiating between groups of ‚Russian‘ migrants in a meaningful way, so that a variety of socio-economic and cultural conditions affecting health can be taken into consideration. In contrast to developments in sociological research, existing epidemiological publications continue treating „ethnic“ groups of Russian Germans and Jews as independent and homogenous entities, overlooking important cultural and socio-economic variations within them. Besides, the overwhelming majority of available studies on health of former Soviet citizens in Germany focuses on Russian Germans only (Ronellenfitsch und Razum 2004, 2006; Kyobutungi, Ronellenfitsch et al. 2006, Wittig, 2004, Schnepf 2002, Beyer 2001, Dreißig 2005), thus neglecting the Jewish migrants, as well as those persons who arrived to Germany unsupported by ethnic minority recruitment programs. One exception is research by Korenblum (Korenblum 2010), which, in contrast, looks at Jewish and Russian German migrants alike.

Hence, to make a contribution to the existing research and to respond to the identified knowledge gaps, this thesis will be based on a sociological approach to health as a phenomenon embedded in a complex system of social stratification and cultural traditions. This thesis will not test a theory about prevalence of some health beliefs, and neither will it pursue establishing sustainable patterns of health inequalities or healthcare utilization in a given migrant population. To conduct such research, secondary quantitative data would have to be addressed, and no such material has been gathered systematically yet. Instead, I will explore and analyze migrants' own conceptualisations of health, and will look for variations between different cases. The question this research sets out to answer, is about 'native' definitions of health, and about people's own ideas about what makes them healthy or ill. I will approach health beliefs and help-seeking behaviours as components of identities acquired in specific socio-economic and cultural contexts of the sending country and throughout the migratory process. Altogether, this thesis will pursue two objectives:

- First, it sets out to explore the effects of Soviet culture on health-related beliefs and behaviours, including healthcare service use. It will regard health beliefs and help-seeking behaviours as components of migrants' identities, attributable to their socialisation in the socialist system, and will question the possibility of *cultural* effects of socialism on attitudes to health. In particular, it will study migrants' beliefs about the effects of nutrition, environment, housing, family structure and employment situation on health,

- Second, this research explores the range of health beliefs and help-seeking practices in migrants from the former USSR in considering highly various patterns of social mobility before and after migration, their relationship to socio-economic status and health practice. This thesis seeks to identify a variety of identities and a variety of health beliefs.

In order to pursue these research objectives, a comparative qualitative research design is used, as outlined in Chapter 2.

Chapter 1 provides with a literature review on existing approaches to socialist cultures of health; to migrants from the former USSR in Germany and elsewhere; and on health as a subject of sociological research. Chapter 2 describes the research setting and the methods used in this project, including issues of translation and interpretation.

Chapter 3 will introduce the research sites and will discuss the migratory processes which have led to the formation of highly heterogeneous migrant communities in different parts of Berlin. It will establish significant cultural and socio-economic differences between groups of institutionally-funded ethnic quota migrants and self-funded migrants, and will set the ground for a discussion of identities, health beliefs and help-seeking behaviours.

Chapter 4 will look at migrants' attitudes to health in a retrospective way. It will describe their different patterns of socialisation in the former USSR distinguishing between three different degrees of empowerment these persons experienced with respect to their health: the disadvantaged, the fragmentally empowered and the privileged. This Chapter will demonstrate that persons in both categories have developed different health beliefs and help-seeking behaviours, thus, arguing against generalisations about Soviet people. In particular, I will discuss the concepts of '*kul'turnost*' (being cultured) and '*takaya zhizn*' („thats how life is“) as core components of health beliefs.

Chapter 5 will look at how these different identities shift and transform throughout the migratory processes, producing new attitudes to health. First, it will look at processes of socio-economic mobility in the ex-Soviet population in Germany, and will argue that persons involved in different migratory processes had significantly different chances of entering the German labour market and achieving relatively high SES. Second, it will look at emerging identity boundaries between groups of migrants and discuss how health beliefs may become markers of those boundaries. In particular, I will discuss how reflexive westernisation of identity affects persons' attitudes to health and serves as a boundary to 'others'.

Chapter 6 will reflect on migrants' conceptualisations of Germany as a 'land of plenty' and their native ideas of health determinants affecting them throughout migration. In particular, it will focus on natural environment, housing and nutrition.

Chapters 7 and 8 will focus on help-seeking behaviours. Chapter 6 will focus on the problem of choice in access to outpatient services, and migrants' strategies of compensating for their lack of choice through informal means. It will also discuss the satisfaction of 'westernised' migrants with German healthcare services and their attempts to make their way in an extremely fragmented system of care. Chapter 7 will look at episodes of inpatient care and migrants' conceptualisation of authority in inpatient setting. In particular, it will look at birthing and pregnancy as cases when migrant women prefer higher degree of intervention, than 'native' German.

The concluding Chapter will discuss the ways in which the literature reviewed in Chapter 2 was used for the analysis of the material gathered. It will look at the main findings of this thesis, discussing the effects of socio-economic gradient of the sending country, of migratory process and of cultural heritage on migrants' health beliefs and help-seeking behaviours. In particular, it will summarise the descent and transformation of *kul'turnost* and *takaya zhizn* („that is how life is‘). The final section of the conclusions will discuss possible policy implications and prospects for future research.

Chapter 1. Literature Review

In the second half of the 20th century sociology and anthropology grew increasingly interested in the ways that people conceptualise health and illness. A constructivist approach in sociology, as well as anthropological research, promoted the understanding that ‘medical belief systems are like any other belief systems, that they are culturally specific and their contents are social in origin’ (Nettleton 2006: 17). Arthur Kleinman (Kleinman 1980; Kleinman 1988), Michael Bury (Bury 1982), Gareth Williams (Williams 1993), Anselm Strauss and Juliet Corbin (Corbin and Strauss 1988) stimulated increasing interest in ‘lay’ interpretations of illness, which has by now become an established subject of sociological research (Nettleton 2006).

Beliefs about health, however, should not be reduced to interpretations of illness. Instead, it is the departure from biomedical understanding of health as a mere absence of disease, what informs sociological model of health. People in different social groups and cultures have distinct ideas about what makes them healthy, and how that state of health can be achieved. Lay accounts often conceptualise health as functional fitness (Bradby 2009: 59), health is described as an ability to perform everyday practices related to employment, social relations or leisure.

Lay conceptualisations of health encompass different dimensions of everyday life, such as nutrition, exercise, working conditions, housing, social relations, religion, healthcare provision, the natural environment and many others. The importance attributed to different aspects of health changes in significance through life course, and also varies by class, gender and cultural heritage. A significant body of research demonstrates that health beliefs are affected by socio-economic status. Lower socio-economic status is often associated with beliefs into external reasons for both health and illness, whereby individuals are considered to have little influence on their condition and are expected to ‘get on’ with what is pre-destined (Blaxter 1983; Cornwell 1984; Pill 1985). Being subject to poor housing, dangerous working conditions or long-term unemployment, and/or interpersonal violence can encourage a view of health as being beyond one’s control. With

higher socio-economic status, beliefs about one's ability (and even duty) to attend to one's health increase are more likely to be manifest (Blair 1993; Williams 1993; Augé and Herzlich 1995). Exercise, nutrition and familiarity with different forms of expert knowledge about health (bio-medical and non-biomedical alike) are often regarded by people with higher educational and occupational status as realms of individual responsibility. Not only material well-being, but also social and cultural capital has a significant effect on health beliefs. For example, research conducted by Richard Rose in post-Soviet Russia demonstrates that independent of income levels, people who thought they could count on informal help provided within their social networks, tended to be more pro-active about their health, than those who did not feel such support (Rose 2000). The importance of social capital for health has also been studied in developed capitalist societies (Berkman 1984; Wilkinson 1996; Berkman 2000). This thesis will also demonstrate the relationship between membership in social networks and health beliefs. Gender differences also have a pronounced effect on health beliefs, as international research demonstrates. In many cultures, including those of the developed capitalist West, women are supposed to care for health of their family members and are attributed with a 'natural' knowledge about health. Research demonstrates that women's conceptualisations of health are more expansive than men's (Blaxter 1990). At the same time, performing the role of a caregiver may also mean jeopardizing women's own health (Doyal 1995; Remennick 2001). Popular models of masculinity are often related to risky behaviors and beliefs that 'health is not a man's domain' (Courtenay 2000; Pietilä 2008).

This thesis will focus, in particular, on how cultural traditions shape ways in which people determine reasons of health of illness, a theme well researched in anthropological (Kleinman 1980, 1988) and sociological (Bradby 1997; Bush 1998; Green 2006) literatures. Culture is extremely hard to define. Existing research into the relationship between culture, health and ethnicity warn against 'essentialist assumption that ethnicity provides a natural and fixed division between population groups' (Nazroo 1998: 710), and against understanding of culture as a static phenomenon. This thesis will follow constructivist approach to culture, and will treat it as heterogeneous and perpetually transforming. The aspects of culture this thesis will focus on are beliefs and behavioural norms, and they will be regarded as created and contested in the process of social interaction, rather than 'inherited' by individuals as self-understood. Besides, culture must not be reduced to a any of its' single components: ethnicity, socio-economic conditioning, political ideology, etc. Drawing upon Barth's theory of identity boundaries (Barth 1969), discussed in the second part of this Chapter in more detail, I will argue that culture is often

used as a mechanism for creation of similarities and differences between the groups. Several contexts in which culture is created and transmitted in interaction are particularly relevant for this thesis: socio-economic mobility, discussed in Chapter 4; processes of co-ethnic migration discussed in Chapters 3 and 5; and complex practices of urban everyday life, discussed in Chapter 3 and 6-8. Family structures also need to be taken into consideration in order to explain how health beliefs are transmitted in the most immediate setting of people's lives, and to place help-seeking practices in context of generation and gender roles. To that end, Margaret Mead's approach, distinguishing between pre-, co- and post-figurative families will be employed, as discussed further in this Chapter and in Chapter 4. In the next section of this Chapter I will discuss how the superficial view of 'socialist' culture as suppressive and 'bad' has been challenged by sociologists and anthropologists, demonstrating significant variations within a culture which was externally labelled as homogenous.

Although initially 'lay' health beliefs and 'expert' knowledge were often contrasted as opposed forms of knowledge (Levin, Katz et al. 1976; Calnan 1987), later research suggests that the power and pervasiveness of biomedical knowledge is such, that there is little or no 'lay' health beliefs untouched by medical understandings (Conrad and Schneider 1980; Cornwell 1984; Conrad 1992; Conrad 2007). Existing research demonstrates that 'lay' and 'medical' knowledge penetrate each other and continuously transform. For example, analyzing medicalization of alcoholism and hyperactivity, Conrad demonstrates how behaviours traditionally attributed to 'badness' of individual character are growing increasingly conceptualised as 'sickness' for which one carries less moral responsibility (Conrad 1980). Cornwell presents a detailed account of how medical knowledge about health becomes incorporated in the health beliefs of lower-class Londoners in the 1980s (Cornwell 1984). In this thesis I will not contrast 'lay' health beliefs with 'biomedical' ones. Instead, I will explore how medical expertise and healthcare systems, among other factors, shape people's understanding of health.

As Nettleton summarises it:

Lay health beliefs are not simply diluted versions of medical knowledge; rather, they are shaped by people's wider milieu, such as their structural location, cultural context, personal biography and social identity (Nettleton 2006: 34).

This conceptualisation of health beliefs as folk conceptualisations rooted in socio-economic stratification, gender roles and cultural identities is at the core of this thesis. By focusing on migrants' health beliefs I will trace the descent and development of socio-economic and cultural conditions, which have shaped their understanding of health and their strategies of help-seeking.

Along with research into health beliefs as forms of knowledge, people's ways of seeking help in a situation of illness were approached by sociologists at different times and different angles. A significant body of research has demonstrated that the scope of actions that people undertake to sustain what they believe to be health, is much broader than consulting an expert. Consultation with a medical professional is only one of the many possible ways to seek information about illness and help. The role of the lay referral system, which may encompass self help groups (Gussow 1976; Gartner 1984), family (Corbin and Strauss 1988; Biegel, Sales et al. 1991) and informal social networks (Berkman 1984; Berkman 2000; Cattell 2001), has been established as crucial in the sociology of health and illness.

To address the wide range of practices relevant to health beyond the medical context, and to stress the reciprocity of interaction, this thesis will employ the concept of *help-seeking* behaviour. As Gourash suggests (1978), research into help-seeking behaviour focuses on formal and informal resources available to individuals, and highlights how social structure influences the circumstances in which people find it appropriate to ask for help, the types of services they utilise, and the effectiveness of the help that they get.

Research into help-seeking practices demonstrates that, similarly to health beliefs, they are also greatly determined by socio-economic factors. For example, individuals with lower socio-economic status have fewer nutritional choices, are exposed to worse working and environmental conditions (James, Nelson et al. 1997; Schrijvers 1998); they often feel neglected and unable to build egalitarian relationships with professional care givers (Cornwell 1984); and the scope of information resources they can reach is also limited (Williams 1993; Williams 2003). Research into class differences in health beliefs and help-seeking patterns (Blaxter 1983; Cornwell 1984; Pill 1985; Blair 1993) demonstrates that groups with low socio-economic status are often pressured to risk their health in order to keep their jobs or to run their households. Structural constraints force people to ignore symptoms, which may be alarming, or interpret them in such a manner that help-seeking is not acceptable.

Hence, accounts of seeking help and definitions of health are complex and encompass a variety of themes. Along with narratives of illness and care,

conceptualisations of nutrition make up an important theme of analysis in this theses. Indeed, food is a central component of health beliefs, given that nutrition is necessary to sustain life itself. Production and consume of food constitutes practices of care and connectedness, as Holloway and Kneafsy argue (Holloway and Kneafsy 2004). The relationship between health, food and identity has been widely reflected upon in the existing literature (Caplan 1997, Lupton 2005), and will be approached in this thesis in Chapters 5 and 6. The analysis presented in these parts of the thesis will be based on the constructivist idea that what is considered healthy food (or food, altogether), encodes identity boundaries and socio-economic differentiation. In Caplan's words: (Caplan 1997: 3):

Food is never 'just food' and its significance can never be purely nutritional. Furthermore, it is intimately bound up with social relations, including those of power, of inclusion and exclusion, as well as with cultural ideas of classification (including the food and non-food, the edible and the inedible), the human body and the meaning of health.

Keeping in mind those definitions and realms of health beliefs and help-seeking behaviours, this literature review will focus on two key themes. First, I will review literature addressing health beliefs and help-seeking behaviours of persons socialised in the former Soviet Union. Second, I will analyse factors, which affect the transformation of beliefs and behaviours throughout the migratory process. Hence, the second part of the literature review will treat approaches developed for understanding migrant health and will look at existing knowledge on migrants from the ex-USSR in Germany.

1.1 Homo Sovieticus: A Disempowered Fatalist or a Struggling Help-Seeker?

After the collapse of the USSR many scholars turned their attention to the specific *culture* of socialism, rather than its political or economic structure, focusing on the everyday practices of the Soviet people (Shlapentokh 1984; Boym 1994; Boym 1994; Neidhart 2002; Gerasimova 2003): 'the utopian topography of the Soviet daily existence and its secret corners, from the Palaces of Culture to communal apartments, from public subways in the magnificent Stalinist style to not-so-private closets, [...] everyday aesthetic experiences and alternative spaces carved between the lines and on the margins of the official discourses' (Boym 1994: 5). Research into health beliefs and help-seeking behaviours constitutes an important part of knowledge about (post)Soviet culture.

Research into how the transformation of the post-Soviet society has affected attitudes to health of persons living in former USSR includes works by Julie Brown, William Cockerham, Mark Field, Laurie Garrett, Galina Lindquist, Ilkka Pietilä, Richard Rose, Michele Rivkin-Fish, Nina Rusinova, Kate Schecter, Vladimir Shkolnikov, Ludmila Shilova, Sergey Shishkin, Anna Temkina, Judith Twigg, Elena Zdravomyslova. Their various publications will be cited throughout this literature review. At the same time, some research about health beliefs and help-seeking practices has been carried out on various groups of immigrants from the ex-Soviet Union to Israel (Remennick 1999; Remennick 2001; Remennick 2003) and the USA (Benisovich 2003; Aroian 2004) two countries which, along with Germany have accepted the greatest number of former USSR citizens. German research on the health of migrants from the former USSR has been carried out by Martina Beyer, Verena Dreißig, Jakob Kirsch, Wladislaw Korenblum, Ulrich Ronnelfitsch, Oliver Razum, Liane Schenk, Winfried Schnepf. Their work will be addressed and cited in the next section of this thesis.

The existing literatures are characterised by a contradiction, which this thesis treats as stimulation for research. On the one hand, some scholars tend to suggest that people socialised in the USSR are profoundly 'different' from Westerners in their understanding of health and their ways to seek help. 'Fatalist' Homo Sovieticus is cast against the 'Enlightened' Westerner as a person shaped by the socialist ideology (Cockerham 2000; Cockerham 2002). On the other hand, other authors argue that internal differences between groups of the former Soviet population are so profound, that no over-generalisations about 'socialist' health beliefs may be made, with different segments of the former Soviet society producing their own distinct identities and attitudes to health (Rusinova and Brown 2003). The following literature review will focus on these

contradictory conceptualisations, and will lead to a discussion of the approach adopted in this thesis.

Throughout the Cold War period, research into the health of Soviet people was hard to undertake, and, therefore, described only fragmentally. Considering the ideological importance of socialised care and its, supposedly, magic effect on life expectancy and the well-being of Soviet people, most research conducted in the USSR on socialised care needs to be taken with a certain degree of scepticism, as has been observed (Field 1967; Knaus 1981; Field 1989; Garrett 2001). Findings which did not fit into the ideological framework of the benefits of the system of socialised healthcare were banned or silenced. Thus, almost no systematic and reliable evidence was collected in the USSR by its own researchers, and the only available data comes from a few scholars from the West who were able to penetrate the Iron Curtain during the Cold War period, with Mark Field and William Knaus publishing important evidence (Field 1957; Field 1967; Knaus 1981; Field 1987; Field 1988; Field 1989). Their research mostly focused on the organisation of healthcare services: structures of doctor-patient relationship, availability of medical help and people's patterns of its utilisation. Although these authors recognise the important role of socialised medicine in successfully fighting the infectious diseases, they criticise the Soviet healthcare system as paternalistic, suppressive and ineffective. Addressing the structure of the medical profession, Mark Field points to the dependent position of a patient, and lack of autonomous decision making among doctors in his publications (Field 1957; Field 1988). William Knaus addresses the organisation of Soviet medical services and stresses their inability to cater to even patients' most basic needs (Knaus 1981). He also observes the heavy utilisation of hospital services in the Soviet population and suggests that it results from overriding poverty: unable to keep ill persons in cramped apartments, or provide them with necessary nutrition, Soviet families became dependent on in-patient services to a far greater extent than families in, for instance, the USA. Field and Knaus both suggest that the socialised free-of-charge medical system, coupled with poor living conditions and shortages, has produced a dependency on healthcare services, and made Soviet people less pro-active about their health, than persons in other countries. As Field argues:

In its attempt to capture and retain the loyalty of its citizens the Soviet regime affirms that one of its major concerns is the welfare of the individual (zabota o cheloveke). In the realm of health the individual is said to be entitled, as a matter of the constitutional right, to high-quality medical assistance at the expense of the

state. This constitutional provision is, of course, constantly and continually commented upon and amplified in all the means of mass communication. It would be very surprising, indeed, if such a campaign did not mold expectations concerning medical care, particularly in view of the fact that it caters to deeply felt anxieties.
(Field 1957:203)

The collapse of the USSR and the subsequent mortality crisis stimulated a dramatic increase in research on the health of citizens of the former Soviet Union. Approaching the reasons for the increasing morbidity and dropping life expectancy in some segments of Soviet society, scholars focused on two major issues: first, they studied the role of the healthcare system in managing the crisis (Schechter 1991; Field 1995; Schechter 1997; Burger, Field et al. 1998; Rivkin-Fish 2005) or, as Garrett suggests, contributing to it (Garrett 2001); and second, they theorised the effects of socio-economic transition on individual health beliefs and help-seeking practices (Brown and Rusinova 1993; Rivkin-Fish 1997; Cockerham 2000; Rose 2000; Brown and Rusinova 2002; Cockerham 2002; Rose 2003; Rusinova and Brown 2003; Rivkin-Fish 2005; Shilova 2005).

In some studies, defunct Soviet healthcare is blamed as one of the reasons for the decline in health outcomes and life expectancy in some segments of the ex-Soviet population. Field (Field 1995; Burger, Field et al. 1998), Schechter (Schechter 1991; Schechter 1997) and Garrett (Garrett 2001) attribute the outbreak of illness and the rapid decrease of life expectancy to the structural problems in Soviet medicine that Knaus and Field pointed out in their earlier works: poor funding, the dependent position of doctors and a lack of nurses. Citing and analysing scattered evidence available from Soviet archives, Garrett and Schechter argue that the deterioration of health outcomes in the Soviet population started in the early 1970s, with the crisis of the 1990s being its logical peak (Schechter 1991; Garrett 2001). Garrett and Schechter suggest that although initially contributing to the elimination of some infectious disease in the early Soviet period, the USSR's system of healthcare proved unable to address problems typical of a developed industrial society: chronic illnesses, cardiovascular problems and cancers, which, among other reasons (alcoholism, accidents and other external reasons) have led to a gradual stagnation and eventual decline in life expectancy by the 1990s. In particular, scholars address declining funding of the USSR medicine as a basis for the deterioration of Soviet people's health (Schechter 1991; Burger, Field et al. 1998; Twigg 1998; Field and Twigg 2000). Whereas in 1960s the Soviet Union was investing about 6% of its GDP in healthcare sector, by the end of 1980s, it was only 2-4%, compared to 6.5-13% in Western

countries (Rivkin-Fish 2005:71). Kate Schechter, a well-known expert on post-Soviet healthcare, argues:

By the end of 1980s, the ageing medical institutions could not provide basic care and specialised high quality care was not even a consideration. Epidemics were spreading, infections were not held in check by primitive sterilisation methods, and the Russian population was no longer receiving even adequate care. Medical education and preparation of medical personnel came under sharper scrutiny as the country tumbled down into an increasingly serious health crisis. Home remedies and homeopathic medicine have become popular. Confidence in the healthcare system has dipped so low that it will take many years to reestablish authority and recover from the setbacks it has suffered (Schechter 1997:40).

Research by Brown, Rusinova and Panova does not attribute the mortality and morbidity crisis to the state of post-Soviet healthcare system, but rather demonstrates the incapacity of medical services to cope with the consequences of the crisis. Evidence gathered by these authors suggests that access to even the most basic primary care provided by territorial polyclinics became increasingly impeded for people living in poverty and having low occupational status (Panova and Rusinova 2005), that is, persons who, according to demographical data, were worst affected by the morbidity and mortality crisis (Shkolnikov, McKee et al. 2001; Andreev, Nolte et al. 2003). Brown and Rusinova demonstrate that in the 1990s the non-utilisation of healthcare became typical not only for individuals with the lowest SES, but also grew increasingly among those segments of the society who and otherwise actively sought medical help, such as qualified manual workers or clerks (Brown and Rusinova 1997; Brown and Rusinova 1999; Rusinova and Brown 2003). Brown and Rusinova explain this trend as part of an increasing distrust in medical knowledge and general scepticism of medical interventions, which people believed to be ‘crippling’ rather than ‘curing’ (Brown and Rusinova 2002). Indeed, it was not just the institutions people thought of as dysfunctional, but also the expertise of its agents that they rejected. Michele Rivkin-Fish argues (Rivkin-Fish 2005: 141):

...In the eyes of many Russian patients, doctors’ licenses as medical experts – as all evidence of their association with the state – not only failed to generate trust but actually raised disturbing suspicions that they would replicate negative practices

associated with the state systems. Their licenses from the state constituted certificated without charisma.

Dysfunctions in the provision of healthcare make up an important research subject, however they do not explain the mortality and morbidity crisis, as Field point out (Field 1995). Instead, Field and Twigg argue that the deterioration of medical services is only secondary to the stressful effects of the socio-economic, political and cultural transition (Field and Twigg 2000), which they call the 'collapse of the safety nets'. They demonstrate that not only formal, state-supported structures, such as healthcare and the labour market, but also private networks, went to pieces throughout the uncertain post-communist transition. Their research, as well as studies by Richard Rose (Rose 2000; Rose 2003), demonstrates that rapidly declining levels of trust and social capital were directly related to the worsening of health in some parts of the post-Soviet society. Unemployment, political uncertainty, poverty and violence, escalating in many post-Soviet regions, had significant effect on people's individual behaviours and their beliefs about health. Indeed, health beliefs and help-seeking practices of the former USSR started drawing increasing attention, being theorised as the driving force behind the crisis (Cockerham 1997; Cockerham 1999; Cockerham 2000; Biloukha 2001; Steptoe 2001; Pietilä 2007; Pietilä 2008).

Works by William Cockerham have been highly influential in this field of research. His approach focuses on effects of socialist political ideology on health. Cockerham's publications influenced the work of other scholars approaching health beliefs and help-seeking behaviours of people socialised in ex-communist societies, both in Russia and abroad (Remennick 1999; Biloukha 2001; Steptoe 2001; Shilova 2002; Remennick 2003; Abbott 2006). Studying beliefs about health and illness, and help-seeking behaviours of the post-Soviet society, Cockerham employs the concept of 'health lifestyles', which he determines as collective patterns of health-related behaviour based on choices from options available to people according to their life chances (Cockerham 2000: 1314). Cockerham suggests that most of the Soviet people across all occupational and income groups were, as individuals, only marginally able to improve their nutrition, working and living conditions, or influence their exposure to environmental pollution. Exposure to dangerous working conditions was typical not only of manual workers, but also of high-ranking researchers who, for example, worked with dangerous elements or radiation without adequate protection. A shortage of accessible sporting facilities caused a lack of exercise across the population, and cramped living conditions often impeded the

maintenance of personal hygiene. Groceries have always had to be queued for, and the range available was severely limited, so that a typical Soviet diet was very rich in carbohydrates and animal fats, lacking proteins, and included only very little fresh fruit and vegetables. Coupled with a centralised healthcare system that Cockerham calls paternalistic, these limitations in the ability to make health-related individual choices, produced, he suggests, a passive attitude towards one's own health.

Research pointing out the 'paternalism' of the socialist state and the 'fatalism' of the Soviet people with respect to their health, indicates important structural problems related to attitudes to health, such as the lack of health education and a tendency to compensate for a permanent lack of resources by increased utilisation of medical care. However, Cockerham's approach tends to over-stress the role of ideology in favour of socio-economic factors, which have been proven to be strongest predictors of 'fatalistic' health beliefs in other developed countries.

Cockerham claims that 'Soviet-style socialism had the potential to induce passivity on the part of many individuals toward health promotion' (Cockerham 2002: 43). He suggests that the Soviet totalitarian state has created a Homo Sovieticus (Cockerham's spelling - P.A.), who, with respect to his or her health is likely to adopt 'negative' lifestyles characterised by alcoholism, excessive smoking, non-utilisation of healthcare services and other health-endangering behaviour. Cockerham argues:

The persistence of Homo Sovieticus personality in the Russian society today, described as a 'collectivist' who rejects individual responsibility supports the notion of a socialist heritage undermining the enactment of positive lifestyle for many people (Cockerham 2002: 52).

Cockerham recognises that some parts of the ex-USSR population are more 'passive' than the others, drawing attention to blue-collar middle-age men as having most 'unhealthy' beliefs about health. However, rather than analysing effects of social inequality on individual health lifestyles, as, for example, Blaxter does (Blaxter 1990), Cockerham tends to attribute differences in health lifestyles across post-Soviet population to differences in ideological beliefs. Explaining passive health beliefs of the blue-collar men, he relates them directly with allegiance to collectivist communist ideology in this social strata. Hence, within his lifestyle approach, collective choices receive a highly politicised explanation. Homo Sovieticus is poorly educated about health, because he does not want to change his socialist beliefs, whereas material conditions of his life are only

secondary to the ideology. In fact, Cockerham finds a direct dependency between poor health outcomes, fatalistic health beliefs and pro-socialist political opinions (Cockerham 2002, Cockerham 2006).

Cockerham's lifestyle approach certainly grasps the general feeling of disempowerment many persons felt in the (post)socialist system with respect to an inability to act as independent individuals. However, as Brown and Rusinova argue, it neglects variations within the 'socialist' culture it looks at, focussing, mostly, on adversities, and regarding post-Communist societies as profoundly different from the Western:

Much research seems implicitly to assume socio-cultural homogeneity, attributing 'unhealthy' behavior to the Soviet system (presumed to have fostered passivity) and/or to wrong-headed individuals (presumed to make bad choices; see, for example, Cockerham 1999). (Brown and Rusinova 2011: 1-2).

Such ideologically biased focus, which Rivkin-Fish attributes to 'Cold War fantasies' (2005: 62), fails to recognise Russia and other ex-Soviet republics as developed countries, where, similarly to the USA or Britain, health beliefs and help-seeking practices are strongly affected by socio-economic inequality and cultural variations, with socialist legacy, perhaps, ominously present, but differently interpreted in various segments of the society. Ideology, critics of Cockerham's approach suggest (as discussed below), is only one cultural factor affecting individual behaviour. This is a criticism this thesis concurs with. The definition of culture suggested in this thesis on page 16, suggests that post-socialist culture, indeed, can not be determined through its ideology only, and, hence, health beliefs and help-seeking practices of the post-Soviet society need to be studied from different angles. Moreover, individual behaviour must be placed in context of other cultural aspects influencing health. Existing research discussed below suggests that socio-economic status (in particular, its educational aspect), inclusion in informal social networks, gender and family structures are factors particularly important for understanding of variations in post-Soviet health culture. Evidence gathered by demographers investigating the post-Soviet mortality and morbidity crises, demonstrates clearly that the deterioration of health had a strong gender and socio-economic gradient. In series of publications Shkolnikov, Andreev and others argue that the mean decline in life expectancy, documented in post-Soviet Russia, needs to be attributed to deaths from external causes in young males without higher education (Shkolnikov, Cornia et al. 1998; Shkolnikov, Leon et al. 1998; Andreev, Nolte et al. 2003, Shkolnikov, Andreev et al. 2004), whereas other parts of the population remained fairly untouched by the crisis. For example, life expectancy of urban Jewish

intelligentsia did not decline, and their illness patterns did not worsen significantly. In contrast to Cockerham, Shkolnikov, Andreev and others attribute significant variations in health outcomes to educational and occupational stratification of the post-Soviet society, rather than their political beliefs (Shkolnikov, Leon et al. 1998; Shkolnikov, Andreev et al. 2004). They suggest that individual behaviours leading to premature death (alcohol abuse, smoking, violence, drunk driving) are much more strongly expressed in less educated parts of the ex-Soviet population. Evidence gathered by Shkolnikov and his colleagues is confirmed by smaller quantitative data sets, and by qualitative research. In studies focused on the relationship of healthcare provision and the mortality crisis, Panova, Rusinova and Brown demonstrate that the falling quality of healthcare provision had different effects on different segments of society (Brown and Rusinova 1997; Brown and Rusinova 1999; Rusinova and Brown 2003; Panova and Rusinova 2005). Michele Rivkin-Fish analyses different pathways to care and strategies of influencing doctor-patient relationship in her excellent publication on women's health in contemporary Russia (Rivkin-Fish 2005). She suggests that educated women were better empowered to seek medical care, being able to rely on informal networks and being recognised by medical professionals as equal in status. Their lay referral system was complex and encompassed institutional gatekeepers of different ranks, so that these women could influence the process of pregnancy supervision and giving birth. Their knowledge of the informal exchange code made them superior in comparison to less educated women who needed to enter the institutional setting by 'official' means and indeed, were often forced into passive roles. Criticising generalisations about passive attitudes to utilisation of healthcare services, Rivkin-Fish suggests that qualities of structure, that is, of the healthcare institutions, have been uncritically ascribed to the agents within them, stripping these agents of individual rationality and complexity of decision-making. Being confronted with such views throughout her collaboration with WHO health campaigners in Petersburg, Michele Rivkin-Fish observes (2005: 62):

The problem with this view is that the image of Russian work setting [hospital] beset by terror of totalitarian repression and betrayal, with colleagues utterly estranged from one another, was founded on Cold War fantasies, rather than any genuine understanding of local workplace dynamics. [...] Providers and patients experienced a variety of kinds of relations and interactions, including intensely intimate bonds of friendship. Hospital staff members enjoyed strong camaraderie as well, if within the lines of vertical difference.

Anna Temkina and Elena Zdravomyslova discuss the role of cultural socialisation for help-seeking behaviours in sexual health (Temkina 2008). Similarly to Rivkin-Fish they argue that education plays the greatest role in the ways that people conceptualise health. They also suggest that education determines gender-specific beliefs about health and gender-specific help-seeking practices. Although health is expected to be a 'woman's business' in all groups, educated men are more likely to take pro-active approach to health and provision of help, in particular, by supporting their partners throughout pregnancy and giving birth. Their research is supported by evidence collected by Pietilä, who suggests that Russian men generally tend to shift the responsibility for health onto women, believing that 'health is not a man's domain' (Pietilä 2008). Nina Rusinova, Julie Brown and Ludmila Panova have carried out a significant body of research on the role of education and social capital invested in health by unequally empowered groups of the population (Brown and Rusinova 1993; Brown and Rusinova 1997; Brown and Rusinova 1999; Brown and Rusinova 2002; Rusinova and Brown 2003; Panova and Rusinova 2005). They also demonstrate that education plays the most significant role in the ways that people conceptualise health and seek help.

Interesting insights into the effect of socio-economic status and cultural differences in health beliefs can be drawn from research on reliance on non-biomedical treatment in the post-Soviet society, carried out by Galina Lindquist (Lindquist 2002; Lindquist 2006). Lindquist suggests that, on the one hand, a great variety of healing options existed in the former USSR (in spite of official bans), and, on the other hand, that their utilisation was characterised by a socio-economic gradient. Her research demonstrates that the rural population and urban manual classes were most likely to rely on strategies of traditional healing performed by '*babki*' (female healers), whereby treatment methods such as whispers, rituals and prayers would be performed. The urban intelligentsia, however, would regard such healers as 'uncivilized', labelling their methods as 'nonsense' and 'superstition'. Having internalized the discourse of modernity by means of higher education, these persons would be more likely to consult healers who were trying to combine – and in fact, to legitimize – their methods with the means and principles of Western biomedicine. Lindquist calls these methods 'quasi-scientific', attributing this categorization to two areas of non-biomedical healing popular in the former USSR and transitional Russia: the so-called bio-energetic healing and oriental traditions. Bio-energetic healing is based on the idea of an individual bio-field surrounding every living creature. Damages to this field are regarded as initial causes of all diseases, and the purpose of healing is, thus, to repair it. Healing procedures include movements over the

body with hands or fingers, combined with prolonged touching, massage and bone-setting manipulations. Bio-energetic healers are often referred to as *ekstrasensy*, and their capabilities have long been a subject of both public and scientific fascination. The oriental traditions are mostly based on Chinese and Indian practice. Practitioners of either method strive to comply with scientific principles of modernity, explaining their healing strategies as measurable, predictable, repeatable and goal-oriented. For example, computer programs have been developed to measure the efficacy of bio-energetic treatment, with its efficacy measured by lab tests conducted in hospitals. Rationality and contempt for 'superstition' are a part of healers' presentation techniques. Such healers used work in an institutional setting more often than folk healers, and rely greatly on references to the scientific establishment, such as licenses of the Ministry of Health or professional certificates (Lindquist 2006)

In contrast to Cockerham's work, cited research encompasses a variety of health beliefs and help-seeking behaviors, . demonstrates that a pro-active approach to different spheres of life, including health, could also be observed in some segments of the society, empowered by access to a broad network of informal services and an 'economy of favours' (Ledeneva 1998; Lonkila 1999; Ledeneva 2006). It is the intricate hierarchy of socio-cultural identities oscillating between polar categories of *'svoi'* (our people) and *'chuzhie'* (strangers), reflected upon in sociological work (Shlapentokh 1984; Ledeneva 2006), that determined beliefs about health and ways persons sought help in a society which was declared to be 'equal'. Galina Lindquist suggests:

Russia both before and after perestroika has been a complex, stratified society, where this 'native sociology' was ubiquitously present. People tended to form close bonds within their own social groups, defined in a more narrow way than the officially recognised distinctions between workers, peasants, and intelligentsia. For example, the big stratum of 'intelligentsia' was further subdivided into 'academic intelligentsia', 'technical intelligentsia', 'creative intelligentsia', and so forth. All those groups were characterised by their own 'habitus', by the set of dispositions and cultural designs that made it easy to recognise svoi, 'ones of our own kind', and to classify and categorise 'the others' with great precision. This was a matter of cultural competence that underlies discursive and performative mastery defining the aesthetics of socialising as well as the emotive substance of social bonds. It involved the joy of being together with svoi, a deeply valued form of socialising

known as *obshchenie*, and also the art of manipulating the members of other social groups as resources of material favours or cultural capital. (Lindquist 2002: 340)

In the current research, differences in socio-cultural identities strongly correlate with, but are not limited to ethnic background. As I will discuss in Chapters 3 and 4 Jewish and self-funded migrants mostly come from the urban intelligentsia, and Russian Germans from agricultural and manual worker background. A variety of cases will be selected within every group of migrants.

Based on the existing knowledge discussed in this section of literature review, I hypothesise that socialism as a culture had, indeed, produced specific health beliefs and help-seeking practices. However, I will demonstrate that initial socialisation in the former USSR had had very diverse effects on persons from different socio-economic and cultural backgrounds. I will demonstrate that Jewish migrants, mostly coming from the urban intelligentsia identify themselves with the concept of *kul'turnost*, that is, being cultured. Michele Rivkin-Fish explains *kul'turnost* as follows:

Kul'turnost is based on a pre-revolutionary Russian notion of kul'tura [high culture] which evokes knowledge of canonical texts of Russian literature and the high level of spirituality they symbolize. Stalin drew on the enormous symbolic capital of kul'tura to promote discipline and conformity to images associated with civilized high society, progress and modernity. Being 'cultured' came to mean having both erudition in classical literature and art and competency in social etiquette, a combination of qualities supposedly antithetical to vulgarity, cruelty and evil. Despite these positive associations, kul'turnost also has been used to signify class, race and cultural difference, serving as a weapon of power and exclusion (Rivkin-Fish 2005:12).

Kul'turnost is also a core concept for understanding of Soviet Jewish health beliefs, as will be discussed in Chapter 4. As for Russian Germans, their identities are mostly rooted in concepts of diligence and family, although some better educated *Aussiedler* also refer to *kul'turnost*, stressing their high status. To trace the descent of these identities and to place them in the context of primary socialisation, I will look at family structures across different groups of migrants by employing Mead's concepts of post-, co- and pre-figurative families (Mead 1970). I will study the relationship between different types of families and patterns of socio-economic mobility in the socialist stratification system, by demonstrating that whereas low SES and rural residency was related to post-figurative structure, living in the city and having higher education meant being a part of pre-figurative family. The focus on families may be explained by their distinct role in transmission of cultural heritage in the

USSR, as discussed by Vladimir Shlapentokh (Shlapentokh 1984; Shlapentokh 1989). Families were recognized as networks of *svoi*, as opposed to the world of *chuzhie*. Private lives in Soviet families could be structured very differently from what the propaganda was suggesting. In Chapter 4 I will discuss ways in which families affected transmission of health beliefs. In Chapters 5 to 8 I will demonstrate that migration affects those identities and family structures, which leads to transformation of health beliefs and help-seeking behaviours.

1.2 Homo Sovieticus Meets Enlightened Westerner: A Soviet Person Abroad. Reviewing Existing Knowledge and Conceptualising an Approach to Health.

Studying migrants from the former USSR provides with a new angle on the transformation of socialist health cultures, in particular, on how attitudes to health observed across various groups transform through the migration process. At the same time, this focus also contributes to knowledge of factors affecting the health of migrants in different countries.

As discussed above, over-generalisations about the effects of socialist ideology on the formation of health beliefs and help-seeking practices were criticised in literature on post-Soviet Russia and other ex-USSR republics. However, the image of Homo Sovieticus remains fairly unchallenged in research on migrants from the former USSR abroad. Scholars in the USA, Israel and Germany indicate low level of awareness about health in this migrant population, for example, Larissa Remennick discusses the non-participation of former Soviet females in Israeli screening programs (Remennick 1999; Remennick 2001; Remennick 2003), and Aroian identifies the lack of a pro-active approach to American healthcare services (Aroian 2004). Although these authors indicate important problems that migrants experience when seeking medical help, they tend to explain them as a 'socialist fatalistic' approach to health, and fail to place their evidence in a wider socio-economic context.

German literature on migrant health has been mostly carried out from an epidemiological and public health perspective, with migrants regarded as a special, deviant case within the established healthcare system; as persons with 'special' illnesses and in need of 'special' treatment methods (David 2000; Borde 2002; David 2002; David and Borde 2002; Borde 2003; David, Schwartau et al. 2006; Borde and David 2007; Borde, Dudenhausen et al. 2008). The epidemiological approach dominates the German debate on public health (and migrant health in particular), with a sociological critique only starting to develop into an independent discipline more recently. To a great extent, this research tradition, as Kneesebeck suggests, results from the persistent strong corporatism of German medical professionals, with social scientists institutionally based within medical faculties and drawing research funding from healthcare organisations (Siegrist, Kneesebeck et al. 2005).

German epidemiologists and sociologists recognise some important limitations which pertain to studies on migrants from the former USSR in their country. Schenk argues that this migrant population is altogether poorly reached by epidemiological and public

health research (Schenk 2005; Schenk 2007). Gaps in knowledge on health outcomes of migrants from the former USSR were not adequately addressed by the latest major German nationwide public health surveys, such as the Migration and Health Special Report (by the Robert-Koch Institut (RKI 2008 (a)), the German Health Interview and Examination Survey for Children and Adolescents (RKI 2008 (b))(known in Germany as KiGGs), and the Fifth Aging Report of Federal Ministry for Seniors, Women and Youth (BMFSFJ 2010).

The missing epidemiological data on migrants from the USSR are not the only problem discussed by German epidemiologists; in fact the knowledge gap on health outcomes and patterns of healthcare utilisation is gradually being addressed. However, scholars point to difficulties in interpreting the epidemiological data they gather (Kyobutungi, Ronellenfitsch et al. 2006; Ronellenfitsch, Kyobutungi et al. 2006; Becher, Razum et al. 2007). Becher, Razum and Ronnelfitsch suggest that there is still a lot to be learnt about factors affecting health of migrants from the former USSR, and about their own beliefs about health. In particular, they argue, the effects of perceived socio-economic mobility on migrants' health needs to be taken into consideration.

In a longitudinal study conducted with a five year period Ronellenfitsch and Razum (2004) have identified a rapid deterioration of self-rated health in immigrants from the ex-USSR. These authors have established that this decline in self-assessed health status occurs independently of documented improvements in migrants' socioeconomic status. Unable to theorize this discrepancy due to a lack of comparable data, authors suggest that deeper insight into the immigrants' life situation is needed to identify disadvantages specific to this group which may go beyond financial and employment issues. In another study by Ronellenfitsch (2006) perceived status also plays an important role. Ronellenfitsch identifies lower levels of cardio-vascular mortality in Russian Germans as compared with cohorts of German population. He explains this morbidity pattern by migrants' higher self-estimated SES than in similar groups of German nationals, and relates it to the transition from life in the former USSR to Germany, which migrants regard as beneficial. However, Ronellenitsch observes that a lack of differentiation between groups of migrants and the resulting failure to make in-depth comparisons between them, make this assumption only provisional. He suggests that better operationalization of *Migrationshintergrund* and a stronger conceptualisation of status need to be carried out.

Becher (Becher, Razum et al. 2007) also argues for the need to study and theorize social, economic and cultural factors affecting the health of migrants from the former USSR in Germany. Identifying increased mortality from non-natural causes in this migrant

population, he highlights the underlying integration problems of Russian Germans, and suggests that:

Migration related stress often results from deterioration in socioeconomic status and problems with integration and assimilation. They suggest that the much increased mortality due to "other non-natural causes" is particularly striking and is likely to result from drug abuse. This would imply social problems or a psychopathological component and offers a potential for prevention (Becher, Razum et al. 2007: 1660).

Analyzing his data, Becher suggests that further research into the effects of socio-economic status and cultural integration on the health of migrants from the former USSR is necessary.

German epidemiological debates suggest that problems in identifying and interpreting concrete factors affecting health of migrants from the former USSR in Germany result from difficulties in the operationalization of *Migrationshintergrund*, the variable meant to identify 'non-German' descent. Razum and Zeeb argue:

Definition of a target group is a serious problem of every epidemiological study. 'Migrant' as general concept is applied to all sorts of groups, including labor migrants, refugees, Aussiedler and others. It is a challenge to clearly operationalise such a heterogenous group. Given the increasing number of persons in possession of German citizenship, nationality as a criterion is losing its power. Migrationshintergrund is being increasingly identified on the basis of country of origin (of a person or their parent (s)), spoken language or name (Razum and Zeeb 2007: 846).

Because, as Schenk (2005, 2007) and Razum (2007) suggest, there has been no standardised model of operationalising *Migrationshintergrund* for epidemiological research developed yet, research into concrete migration-related effects on different groups of migrants was almost impossible to carry out. A vague definition of migrant status, as well as of the native population groups involved in the samples, have made comparative studies difficult to carry out or interpret. Neither sampling, nor analysis can be carried out effectively when target groups are not defined.

Indeed, as Schenk suggests, it is a definition of migrant status based on nationality which causes the neglect of migrants from the former USSR in German epidemiological

research (Schenk 2005, Schenk 2007). As mentioned in the introduction, up until the early 2000s Germany had officially been declaring itself a non-immigration, ethnically homogenous country united by *Leitkultur* (leading culture), and no political incentives were in place to motivate the development of variables describing ethnicity. Nationality served as major census data proxy measure of non-German descent, with Turks being a prominent and easily identifiable group. In contrast to *Gastarbeiter*, the overwhelming majority of migrants from the former USSR were in possession of German citizenship and no longer being registered as 'foreigners', thereby remaining 'invisible' for epidemiological research based on census data. The existing research, attempting to cover the knowledge gap, is important in as much as it draws attention to the 'Russian' migrant population in Germany, however, it is not yet sufficient to explain concrete factors affecting the health of persons from the former USSR, given that *Migrationshintergrund* remains poorly operationalised, as Ronellenfitsch and Razum suggest (Ronellenfitsch and Razum 2004). One of the key drawbacks of this research is that it reduces *Migrationshintergrund* to ascribed ethnicity. External ethnicity-based categorisations are criticised in international literature for the 'reproduction of racialised categorisations, overemphasis of homogeneity within groups and contrast between them, and failure to offer terms with which people identify and which can express complex identities' (Bradby 2003: 5). Failing to capture significant internal heterogeneity within the ex-Soviet migrant population leads to the distorted interpretation of health beliefs and help-seeking behaviours and, sometimes, to replication of Homo Sovieticus approach. Korenblum (2010) and Kirsch (2004) attribute 'passivity' in health beliefs to migrants' Soviet past. A similar statement is made by Wittig (Wittig 2004) who attributes migrants' difficulties using the German healthcare system mostly to effects of socialisation in the Soviet medical system. 'Different culture' as an explanation of healthcare utilisation also appears in studies by Schnepf (Schnepf 2002), Beyer (Beyer 2001) and Dreißig (Dreißig 2005). Studying migrants from the former USSR in the context of hospital care, Dreißig suggest that they are unable to make the autonomous decisions about treatment that the German healthcare system expects them to. Schnepf and Beyer indicate low levels of nursing care utilisation by elderly Russian Germans and attribute it to a reliance on informal family care related to 'traditional culture'. Indeed, as I will discuss in Chapter 4, coming from manual-class, rural background, Russian Germans tend to attribute health to external factors and be 'passive' about their health. However, other groups of migrants present with very different beliefs and behaviours, which are not documented in existing German research.

Difficulties in addressing ethnicity and identifying migrant descent in health research have been discussed in international literature (Bradby 2003; Ahmad 2007). Like academics in Britain and elsewhere, German scholars recognise that *Migrationshintergrund* needs to be given better theorisation, and that groups of 'migrant' and 'native' population need to be defined clearly in epidemiological and sociological research on health. Liane Schenk suggests that operationalisation of 'migrant' background needs to encompass country of origin, duration of stay in the receiving country, age of arrival and legal status (Schenk 2005). Besides, she argues that migrants' socio-economic mobility and their identities need to be given better conceptualisation, and suggests that migration-specific effects on status and cultures need to be theorised (Schenk 2006).

This thesis distinguishes between three groups of migrants from the former USSR. The first two groups are Russian German and Jewish migrants who have arrived to Germany by means of institutionally-funded recruitment programs (as discussed in Chapter 3). Significant differences in their descent, discussed in Chapter 4, suggest that they need to be treated as separate groups. A third group are self-funded migrants who have arrived to Germany independently and for variety of reasons. The reason they are differentiated from the first two groups, is the nature of their migratory process, implying specific patterns of socio-economic mobility (as discussed in Chapters 3 and 4). All persons from the ex-USSR interviewed in this thesis are first-generation migrants, who have arrived in Germany between the early 1970s and the late 1990s. This selection is mostly due to the character of the migratory processes from the ex-USSR, with the overwhelming majority of people coming to Germany after 1989, so that the adult migrant population this thesis is focusing on, is mostly composed of first-generation migrants. Hence, all interview participants determined as migrants were initially socialised in the USSR or in a post-Soviet setting, and have direct experience of migration. Those persons who left the former USSR at an early age, have some memories of their childhood and can tell of the migration process that their families were involved in.

The non-migrants, who are compared to migrant informants (as discussed in Chapter 2) are 'native' Germans, that is people born in the territory of today's re-unified Germany, having spent most of their life there and having no experience of migration in the parent generation. This thesis distinguishes between the former 'Ossis' (former GDR citizens) and 'Wessis' (former FRG citizens), given that identity boundaries between them remain persistent after the re-unification (Noelle-Neumann 1991; Dodds 1998; Pryor 2005), and that existing research demonstrates diverging health beliefs in East and West

Germans (Lüschen, Geling et al 1997). Therefore, former East and former West Germans alike were interviewed in the course of the study and compared to migrants.

Describing ‚migrant background‘ in its relation to health, I will focus on migrants‘ own identities, rather than on ascribed ethnic status which, in case of *Aussiedler* and *Kontingentflüchtlinge*, coincides with their legal status. Identities of migrants from the former USSR have been approached in German and international research by several scholars. Dietz mostly focuses on Russian Germans (Dietz 1992, 1995, 1999), whereas Doomernik, Schoeps, Becker and Kessler (Doomernik 1997; Schoeps 1999; Becker 2001; Kessler 2003) mostly look at Soviet Jews. Cultural differences and similarities between the Germans from Russia and the German nationals, as well as between Soviet Jews and members of the local Jewish communities were approached in the majority of these studies in terms of ethnicity (Dembon 1994; Dietz 1995; Graudenz and Römhild 1996; Schoeps 1996; Eisfeld 1999; Becker 2001; Engelkemier 2001; Roesler 2003; Eyselein 2006; Hegner 2008), whereby scholars were setting out to find which meanings migrants attributed to being Russian, German or Jewish. As specific traits of the ethnic minorities from the ex-USSR in Germany, researchers have highlighted traditional structures of the Russian German extended families (Dietz 1999 ; Beyer 2001); the agnosticism and self-identification of Jewish migrants with Soviet ‚high‘ culture (Kessler 2003; Schoeps 1996; Becker 2001). The search for differences sometimes led to a declaration of pathologies, with Russian Germans drawing attention by their supposedly higher standing in the ‘local’ population’s crime rates (in terms of both committing and being a victim of crime) (Ostendorf 2007); and with Jewish migrants being ‘ignorant’ of religious rites and Ashkenazi tradition (Schoeps 1996; Kessler 2003). These studies demonstrate that neither Russian Germans, nor Jews fit into ethnicity-based cultural categories imposed on them by the receiving society.

Indeed, cultural self-identification does not have to be directly related to formal ethnic status (Jenkins 1994). Evidence gathered by Dietz, Schoeps, Kessler and Becker suggests that institutionally-determined membership of a Russian German or Jewish ethnic minority often does not explain the ways that migrants themselves conceptualise their cultural heritage. Migrants from the former USSR conceptualise their ethnicity in a variety of ways, sometimes as ‚Russians‘, sometimes as ‚Soviets‘ and sometimes as Jews or Germans. Hence, context plays a significant role in ways people identify themselves.

The nature of ethnic identity is, in Barth’s word, *transactional* (Barth 1969), with diverging external and internal definitions of self. Barth offers a situational model of identity, characterised by negotiation between social actors. Barth suggests that identities

are created in transactions at and across *boundaries* between internal self-identifications and categorisations (Barth 1969, Jenkins 1998). Identity in this perspective is a *process*, which undergoes perpetual *transformation*. Jenkins suggests that ,ethnic identity is to be understood and theorised as an example of social identity in general and that externally located processes are enormously influential in the production and reproduction of social identity‘ (Jenkins 1994: 197). In that respect, it must be kept in mind that Soviet leaders attempted to eliminate ethnic *groups* rooted in the process of internal ethnic self-definition, and, instead, established *categories* with ethnicity serving as an ascribed institutionalised status, often meaning exposure to discrimination (Brubaker 1994; Tishkov 1997). As I will discuss in Chapter 4, under the pressure of a socialist ideology, most Russian Germans and Jews alike have lost a meaningful connection with their ethnic and religious background, and developed a stronger identification with their socio-economic class. ‘Russian German‘ and ‘Soviet Jewish‘ generally refers to distinct variations of ‘Soviet‘ identities, rather than to independent ethnic cultures. Although academic literature addresses the meaning of ‘Soviet‘ identity to migrants from the former USSR in a limited fashion, people’s identification with the socialist past and cultural heritage are an important component of literary and artistic work produced by migrants from the former USSR in Germany (Kaminer 2002; Gorelik 2006; Kaminer 2006). However, by addressing socialist culture as an important identity component, I will avoid treating migrants as embodiments of Homo Sovieticus. Instead, as discussed in the previous section, I will delineate differences in migrants’ initial socialisation and will demonstrate that coming from different segments of the (post) Soviet society, people studied in this research internalized different health beliefs and help-seeking behaviours.

Migratory processes have further contributed to the transformation of Russian German and Jewish identities, producing new forms of external categorisation and internal self-identification. The receiving society categorises migrants from the former USSR as strangers, often addressing them as ,Russians‘, as will be discussed in Chapter 8, and more often than not attributing negative connotations to their descent. Often, being refused to enter the labour market with their ,Soviet‘ diplomas, migrants from the former USSR become integrated into the lowest-income, welfare-dependent and long-term unemployed segment of the German population (Dietz and Hilkes 1992; Dietz 1995; Schoeps 1996; Damelang 2011). The experience of stigmatisation is also documented, both in academic literature (Becker 2001; Wierling 2004) and in migrants’ own literary work (Reiser 2002; Gorelik 2006). A concentration of Russian-speaking migrants in the least attractive parts of German cities is also an issue observed in existing research (Dietz 1999). As discussed in

the first section of the literature review, low SES is often associated with beliefs about an inability to affect one's health and with difficulties in seeking professional medical help. Hence, unemployment, stigmatisation and urban ghettoisation documented with respect to migrants from the former USSR in Germany need to be regarded as factors possibly affecting their health beliefs and help-seeking practices.

Besides being categorised externally, migrants develop new categorisations for each other and for native Germans. Throughout migration, groups of persons who were almost completely disengaged from one other in their sending countries, came into close contact and became categorised as a culturally homogenous whole by the receiving society. This experience led to emergence of *identity boundaries* and to establishment of relatively hermetic migrant communities. These communities produce cultural and social capital, not necessarily shared with other local populations, and having ambiguous effects on migrants' lives. Werbner demonstrates how self-identification with and inclusion into migrant networks may facilitate access to the labour market and promote socio-economic mobility (Werbner 1990) . For example, even persons with lowest SES may benefit from informal exchange, or, officially long-term unemployed migrants may be involved in shadow or altogether illegal forms of ethnic entrepreneurship. However, Werbner also suggests that migrant networks may contribute to cultural isolation and impose restrictive social roles. Her argument is supported by Vasta, who explores the darker sides of social networks.

[W]hile social networks consist of high levels of social capital, they can also be exploitative and marginalising of various members; there may be unequal forms of political control and unfair redistribution of resources; differences between older and newer members may exist. (Vasta 2004: 17)

Some research conducted in groups of migrants from the former USSR in Germany also suggests that networks have a significant effect on their socio-economic mobility and cultural integration. Doomernik demonstrates the ambivalent effect of social networks developed by Jewish migrants in transitional camps where they were placed upon arrival (Doomernik 1997). He discusses how such networks provided a sense of social support and served as a safety net for finding housing, with persons from one camp seeking permanent housing collectively. However, he also stresses that reliance on these networks led to encapsulation in a migrant community densely populating a given neighbourhood, leading to long-term unemployment and a poor conduct of the German language. Instead,

he demonstrates that persons who had support from beyond the camp networks were better able to seek housing individually and found jobs sooner. Dietz discusses the effect of Russian German extended families on housing choices and employment mobility, also demonstrating that reliance on strong ties may play a positive role in the first months upon migration, however, starts having an increasingly negative effect in the longer run, resulting in unemployment and a poor knowledge of German (Dietz 1999).

The effect of cultural norms transmitted in migrant networks on health is also ambivalent. Evidence gathered in Israel by Remennick and in Germany by Schnepf and Beyer suggests that persons from the former USSR compensate for difficulties in gaining access to healthcare services by reliance on home medicine and home nursing care, with women being in charge of them (Beyer 2001; Remennick 2001; Schnepf 2002). Cultural tradition as a response to socio-economic constraint may empower some persons, and limit others, with caregivers pressured to risk their health for the sake of others. In particular, women tend to be overloaded by the role of an informal caregiver.

In this research I will demonstrate that persons who have acquired different identities through their socialisation in the USSR, mobilise different cultural traditions in order to adjust themselves to the new society. Their distinct patterns of socio-economic mobility also strongly affect the ways in which they re-consider their cultures and re-think traditional roles. For example, in Chapter 6 I will discuss how Russian Germans draw upon traditional family structures in order to battle illness. The Jewish urban intelligentsia, instead, re-constructs itself as 'westernised', mimicking help-seeking practices of the West German urban upper class.

Summary

This review of the complex and controversial discussions has demonstrated the importance of approaching socialist culture as a complex, perpetually transforming and internally heterogeneous phenomenon, rather than a set ideology determined by those in power and uniformly inherited by all Soviet people.

First, this thesis will delineate health beliefs and help-seeking behaviours retrospectively, studying the effects of Soviet stratification and cultural differentiation on persons coming from different socio-economic and cultural backgrounds. In a cross-sectional comparison I will demonstrate that initial socialisation in the USSR has had different effects on various groups of migrants.

Second, a review of existing published research into the health of migrants from the former USSR shows that the knowledge is scarce and, coming from an epidemiological perspective, tends to focus on health outcomes and patterns of healthcare utilisation. A need to theorise socio-economic and cultural effects on the health of migrants from the former USSR in Germany, has been outlined.

This thesis is based on a sociological approach to health as a phenomenon embedded both in a complex system of social stratification and in cultural traditions. Rather than testing a theory about possible prevalence of particular health beliefs or help-seeking practices, this thesis will establish people's own definitions and conceptualisations of health, and will analyse variations between cases in contexts of different identities. Qualitative research based on semi-structured, as the next Chapter will discuss, will provide with material necessary to carry out such analysis.

Chapter 2. Research Methodology

The research presented in this thesis is based on qualitative methodology with semi-structured interviews being the main method of data collection (as discussed below). This choice is determined by the existing knowledge on the research subject, on the one hand, and by research question and objectives of this thesis, on the other. First, the current state of knowledge is such that the task is at most to formulate hypotheses, which can only be done by qualitative research. Once such hypothesis will have been formulated, prospects for future quantitative research will become possible. Second, as discussed in the introduction and in Chapter 1, this thesis seeks to explore migrants' own definitions of health as components of identities acquired in the specific socio-economic and cultural contexts of their sending country and throughout the migratory process.

Hence, informed by explorative approach, this thesis is not testing a theory. For example, it does not seek to find out, whether all migrants from the former USSR are fatalistic about health, or not. Instead, it seeks to identify a variety of identities and a variety of health beliefs (of which some may, and others may not be, indeed, fatalistic). In this research I am setting out to explain the relationship between transforming identities and transforming health beliefs from observations and findings derived from fieldwork. This objective implies reliance on the inductive and constructivist approach associated with qualitative methodology (Bryman 2008). Indeed, this thesis embodies a view of social reality as a constantly shifting emergent property of individuals' creation', which, according to Bryman is a major feature of qualitative methodology (Bryman 2008: 22). The benefits of qualitative research for exploring the relationship between migrants' identities, their socio-economic mobility and their health beliefs are outlined by Smaje:

Ethnographic techniques can illuminate important questions such as the social meanings imputed to health in different populations and the nature of participation in family and community networks which help promote health and welfare. Most crucially (...) such work can also prepare the way for examining how ethnic identities are constructed and maintained, and in beginning to analyse the variety of possible ways this might affect health. Smaje (1996: 165-166):

Because this thesis places health in context of identities, gathering people's own definitions of health and, altogether, studying their own health vocabulary is an

indispensable part of analysis. Qualitative semi-structured interviewing, focussed on health beliefs and ways people seek help, is particularly useful for this type of research. Interviews permit studying ways people place health in general contexts of their lives, and trace connections they make between health and other aspects of their biographies. Establishing concepts migrants from the former USSR use to address health is a particularly important part of this thesis, given that almost no secondary data on this issue is available. Interviewing, as Byrne suggests,

[I]s a particularly suitable method for accessing complex issues such as values and understanding, [because] it is a flexible medium and, to a certain extent, allows interviewees to speak in their own voices and with their own language. Thus, qualitative interviewing has been particularly attractive to researchers who want to explore voices and experiences which they believed have been ignored, misrepresented or suppressed in the past (Byrne 2012: 206).

The details on interview schedule, prompt questions and themes will be discussed in section 2.2 of this chapter.

All interviews conducted in the course of this project were analysed with the help of NVIVO 8. Given that the material was multilingual and had to be translated into English for the purposes of writing up (as discussed in section 2.4 of this chapter), I did not transcribe the interviews at their full length. Instead, I coded the audio files directly, translating the bits of interviews which later had to be used as quotes. Throughout the coding process I was particularly focused on establishing the 'native' health vocabulary. I started coding by looking for definitions of health and illness, and, at the later stage was able to establish two central concepts of kul'turnost and takaya zhizn ('that is how life is'), which will be consistently addressed throughout this thesis.

2.1 Research Design

To identify and explain distinct health beliefs and help-seeking behaviours of migrants from the former USSR, a comparative research design was adopted in this thesis, whereby internal (across migrant groups) and external (migrants VS non-migrants) differences in health beliefs and help-seeking practices were investigated.

The goal of structured comparison by qualitative methods is to provide a rich and systematic account of socio-economic and cultural effects on health beliefs and help-seeking practices. Such a perspective offers consequential and systematic comparison of least contrasting and most contrasting cases, a principle incorporated in the sampling strategy of this research design. This methodological approach sets out to fulfill the goal of this research, that is, to demonstrate the greatest possible diversity of health beliefs and help-seeking practices.

Hence, this research, on the one hand, contrasts all migrant cases with all native German cases in order to find out whether some health beliefs and help-seeking behaviours make up a component of all migrants' identities and may be attributed to their socialisation in the socialist system. On the other hand, all migrant cases will be compared to all East German cases, to explore the differences in attitudes to health in the former USSR and the former GDR. These comparisons can be called '**culture driven**'.

To establish the effects of a socio-economic status on identities and health beliefs and help-seeking practices as components of those identities, '**status driven**' comparisons will be carried out. Status will be approached in a broad weberian perspective. Weber considers status to be prestige or honour in the community, and roots it in social and cultural factors such as family background, lifestyle, and social networks (Weber 1964). Such an approach to status, which encompasses more than the possession of property or means of production, is widely discussed in migrant health research. Approaching difficulties in operationalizing status in research on migrant health, scholars suggest that income or occupational based measures may have little explanatory power for health inequalities experienced by migrants. Direct or indirect experience of racism, persistently precarious work situation, and ecological effects of poor residence area are distinct factors affecting migrants' health, and must be taken into consideration (Nazroo 1998). In order to address these issues, this research will gather retrospective accounts of attitudes to health, analysing the role of social mobility on formation of health beliefs and help-seeking behaviours. Setting out to relate socio-economic status to the living conditions migrants are exposed to in their daily lives (as Nazroo suggests), this research

will adopt a *working hypothesis* that an individual's area of residency may serve as a proxy measure of SES. As existing research demonstrates, residential status and health beliefs are often related to each other. Neighbourhood infrastructure, that is, housing, shopping, and sporting facilities public spaces, natural environment, transportation and other components, may have *structural* effects on health (Macintyre, Ellaway et al. 2002). At the same time, neighbourhoods have *compositional* effects on health, related to social status of people populating them. Residential networks may be supportive in one ways, and destructive in others, and, thus, affect health in different ways (Cornwell 1984; Cattell 2001).

Two sites with contrasting types of living conditions will be compared in this research: a 'rich' and a 'poor' neighbourhood. In both neighbourhoods both migrant and native informants were recruited.

To meet the methodological objective of covering the greatest variety of cases, fieldwork needs to be carried out at research sites characterised by a high diversity of migrant and non-migrant population, both in cultural and socio-economic terms. Berlin, the German capital of 3.5 million people, meets such criteria very well. First, unlike other German cities, Berlin has a long history of a 'Russian' presence, dating back to the 1920s. Given that West Berlin had one of the most significant Jewish communities in the post-war period, it has also accepted Jewish migrants throughout the Cold War era, with a part of today's 'Russian' community being composed of such early migrants. Second, as an independent federal land, Berlin has received a significant quota of Jewish and Russian German migrants alike, with members of both migrant groups establishing themselves in the city throughout the 1990s (Doomernik 1997; Oswald 1997; 2008). Third, the recent history of Berlin as a divided city permits recruitment of former GDR and former FRG persons alike. Fourth, Berlin's population is highly diverse in terms of socio-economic status whether individuals or neighbourhoods are taken as the unit of comparison, as the Berlin Sozio-Economic Atlas suggests (Senaverwaltung für Gesundheit, Umwelt und Verbraucherschutz 2008).

Two Berlin neighbourhoods were selected as contrasting, and thus suitable for carrying out comparative research: Marzahn-Hellersdorf in former East Berlin, and Charlottenburg-Wilmersdorf in former West Berlin. Whereas Marzahn is an outlying neighbourhood with housing among the cheapest in Berlin, Charlottenburg is a flourishing, central bourgeois neighbourhood. Marzahn is often referred to as a 'Plattenbaudorf' – 'concrete village'. Charlottenburg, by contrast, is a neighbourhood where plenty of old,

well-renovated buildings have been carefully preserved. New apartment blocks are small and much less anonymous than in Marzahn.

The provision of statistics on actual number of migrants in these city districts is greatly impeded by the inclusion of the great majority of Russian Germans into the category of German citizens. However, some estimations suggest that each of these neighbourhoods is home to 25-50 000 Russian Germans and Soviet Jews.



Figure 1: The location of Charlottenburg and Marzahn in Berlin



Figure 2: Marzahn



Figure 3: Charlottenburg.

2.2 Research methods: semi-structured lay and expert interviews

Since Russian is my mother language, and my German is very fluent, it was possible to conduct interviews in both languages, according to the needs of each interview participant. The issues of multilingual fieldwork will be reflected upon in section 2.4 of this Chapter.

Two types of interviews were carried out: interviews with 'lay' participants and expert interviews. The full list of interview participants is available in Appendix I to this thesis.

2.1.1 Lay interviews (N = 27)

Interviews with 'lay' participants started with persons introducing themselves and continued first, as a discussion of self-defined illness episodes and persons' responses to them, and, second, with people defining health in their own terms. Such an approach facilitated a relatively natural conversation, contextualising health beliefs and help-seeking practices in people's biographies.

To kick off a conversation, all interview participants were asked to tell me about themselves ('Please, introduce yourself and tell me about yourself whatever you consider to be appropriate, or whatever you are willing to tell me', as translated from Russian or German). This free introduction allowed an investigation of the way persons constructed their identities and the way they reflected on their biographies. For example, whereas some interview participants spoke of their lives as a sequence of professional achievements, others focused on family issues. Soliciting an open introduction usually established the place of migration and/or whether German re-unification was an important process in that person's narrative or identity. Indeed, many of my migrant interview participants started their story about themselves by identifying their legal status as immigrants and stating their ethnicity; some native Germans stated being 'Ossis' or 'Wessis' in the first minutes of the conversation.

In many cases there was no need to prompt the interview participants to talk about illness episodes once the 'introduction' part was done. In fact, no neat border could be drawn between the introduction and the focused part of the interview, given that persons were informed about the topic of the interview, they would embed illness episodes in their biographical narrative, placing them in contexts of their everyday lives. In cases when persons needed prompting, they were asked about the latest illness episode which had

occurred to them or their family. Prompt questions, such as, for example, 'How did it happen?', 'What did you do about it?', 'Did it help?' were also employed in soliciting details of illness episodes. In generating illness narratives I was focusing on the way that people classify illness episodes and what kinds of action they undertake and what kind of ties they mobilize in each case. Setting out to explore the diversity of cases, I was particularly interested in how illness episodes were defined differently for people of different ages, gender, occupational status and culture, and how different resources were sought in each case. The areas I focused on when discussing illness episodes are as outlined by Gourash (1978):

- Who seeks help?
- How does the social network influence the type of help sought?
- What are the outcomes of the helping interaction?

The exact themes I focused on in discussion of illness episodes listed below should not be mistaken for interview questions; instead, they served as a check-list for interview structure. The exact wording of the related questions depended on the interview situation.

Illness episodes, health and significant biographic events:

- Events that in informants' opinion have had greatest effect on their health
- Relation of described illness episodes with other events in informants' lives

Health and family:

- Main care providers in the family
- Differences in behaviour of family members in case of illness
- Distribution of labour within the household

Occupation and health

- The effect of occupation on help-seeking practices

Limitations and resources in sustaining health

- Material
- Cultural
- Institutional

Once a discussion of illness episodes had covered all (or most) of the above listed themes, I asked the interview participants to define a healthy person and whether they considered themselves to be healthy. These questions were not aimed at establishing self-rated health, given that this research is not looking at health outcomes, neither subjectively, nor objectively measured. Instead, this discussion explored migrants' beliefs about reasons for good or bad health, their general conceptualisations of health and their beliefs about their own ability to influence it. Besides, a discussion of health was necessary to shift the focus from pathology of illness episodes to everyday practice.

2.1.2 Expert interviews (N = 8)

Three groups of experts were involved in this research in order to provide additional perspectives on migrants' help-seeking practices.

1. Medical professionals catering to migrants from the former USSR
2. Employees and volunteers in migrant community centres
3. Social workers providing help to both migrant and non-migrant households

The focus of these interviews was two fold.

On the one hand, they were carried out in order to find out whether experts working with migrants observed any differences in their health-related behaviours compared with those of their non-migrant clients. On the other hand, these interviews sought to establish factors which experts attributed to the differences they observed.

In order to personalise the discussion with experts, the interviews focused on episodes of interaction with clients or patients, both migrants and non-migrants. An interview would usually open as follows: 'Tell me about the clients/patients that you see during a typical working day'. The interview sought to establish which divisions doctors/community social workers used to typify their clients/patients, and whether the migrant/non-migrant distinction was important for them. In case such a distinction was not raised spontaneously, I prompted for it. For example, I asked whether these experts had any clients with a migrant background. Although the concept of *Migrationshintergrund* is criticised for being blurry for analytical purposes (as discussed in the literature review), it was used in the interviews providing insights into interpretations of 'migrant background' experts have themselves.

The themes expert interviews focused on were as follows:

- Consultations

What kind of problems do people present with? Do migrants and locals ask for help in similar circumstances? Do migrants and locals have different expectations about the help that can be provided?

- Difficulties in provision of help

What are the particular difficulties that you face in providing care/services? Are there any particular difficulties specific to working with migrants? How can these difficulties be overcome?

As in the case of 'lay' interview participants, migrant and non-migrant persons alike were selected as experts.

Interview material was collected in three major phases. Initially ten were conducted with migrants in Marzahn and in Charlottenburg and an initial set of categories pertaining to the relationships between health and identities emerged, specifically the notions of *takaya zhisn* (,that is how life is') and *ku'lturnost* (being cultured) which I will discuss in Chapter 4. At the same time, my understanding of the complexities of the structure of the migrant population was developing, as I encountered an increasing range of migrants. Throughout the second phase of my fieldwork I was aiming to recruit as many different types of cases as possible, and to investigate the genealogy and contextualization of *kul'turnost* and *takaya zhisn* as health beliefs. Throughout the third phase, interviews with native Germans and experts were carried out.

2.3 Sampling and recruitment strategy. Aspects of fieldwork.

Based on the comparative approach adopted in this thesis, a principle of matched sampling was adopted, with migrant and non-migrant persons interviewed in the course of fieldwork in both neighbourhoods. Altogether, 35 interviews were carried out. The list of interview participants is located in Appendix I to this thesis.

Taking into consideration the intricate relationship between collective and individual health beliefs and help-seeking practices developing in a family, fieldwork was carried out with households, rather than single informants. In order to ensure a focused comparison perspective, I was aiming to recruit most contrasting and most similar cases within both neighbourhoods. For example, in Marzahn a migrant family with four children and a German family with four children, were interviewed and compared with each other; in Charlottenburg an elderly single Russian German woman and an elderly Jewish widow were included in the sample.

The households in either neighbourhood were matched along the following major principles:

- Generation and gender structure;
- Duration of stay in Germany; legal status (for migrant families);
- Presence of serious debilitating chronic conditions among immediate family members.

These principles were employed to ensure a fair spread of cases in every group of informants and reveal factors which influence help-seeking behaviour across different status and cultural groups. Given difficulties in accessing the field (as discussed below), it was not always possible to find fitting matches. In this case, a household that matched on at least one of the principles was located. The table below demonstrates all matching cases and one missing case:

	Family with children in the household	Two-person household, no children	Single-Person household	Households of persons over 65	Single-person household over 65
Marzahn					
Native	1	1	1	1	1
Migrant	2	3	1 (also interviewed as expert)	3	2
Charlottenburg					
Native	3	1	0	1	1
Migrant	4	3	1	1	2

Table 1: Overview of the matching sample

To ensure the greatest variety of cases, several points of entry to the field were selected for either neighbourhood. Formal and informal methods were used to create a variety of snowballs, and both were related to expected and unexpected limitations.

The selection of experts was partially based on information published in the ‘Russian Berlin’ address book, and partially resulted from material I gathered from ‘lay’ interview participants (some medical professionals were mentioned by different interview participants, and I contacted them). Experts were not the main focus of this thesis, and the matching principle was not observed for recruitment.

1. Migrant organisations:

In both neighbourhoods, organisations catering to the needs of migrants (by a variety of means, such as legal advice, language courses, etc) were located and contacted. In the case of Charlottenburg Jews the choice of such organisations was determined by the structure of their migratory process: the Berlin Jewish Community House, located in the middle of the neighbourhood, is an organisation formally responsible for supporting this group of migrants in all aspects of their lives (from legal status to cultural events). Seeking entrance into the Community, I contacted a few of its officials by different means (e-mails with a brief project description, telephone conversations and personal meetings at Community events), asking for their help in meeting other members and introducing my research to them. In the case of Russian Germans the choice of organisation was less direct: although this group of migrants has a centralised organisation called Landsmen Union, Marzahn, in fact, offers a variety of different migrant-focused social work projects, with migrants’ formal networks being more fragmented. In

order to develop a better understanding of their structure, I contacted an editor of a Russian language supplement to a neighbourhood newspaper, a person, who regularly reports on such projects and, in fact, runs one of them. The role of journalists as community network brokers in 'Russian' Berlin has been also highlighted by the existing research (Darieva and Schütte 1997). With this editor's help two further organisations were contacted: a language-course NGO teaching German to *Aussiedler*, and a municipally sponsored community centre (Marzahn Quartiersmanagement).

Several important limitations were related to this strategy. First, it only permitted persons seeking help from these formal organisations or participating in their events to be recruited as interviewees. Persons not utilizing their services for a variety of reasons, thus, remained excluded and needed to be recruited by other means. Second, it fully excluded non-migrant research participants.

Third and, perhaps, most important for the topic of this research, recruitment by formal channels was characterised by a great degree of distrust on the side of institutional gatekeepers, on the one hand, and regular organisation members, on the other. As I will demonstrate in Chapter 5, different groups of migrants express various degrees of hostility towards each other, and thus, strive to maintain strong identity boundaries and keep their communities closed to strangers. As I will discuss further, such segregation strategies result, to a great extent, from migrants' precarious socio-economic situation and their direct dependency on sources of material and non-material support distributed by their formal organisations. Any penetration into the organisation is regarded as a potentially threatening intervention into the distribution process. Many migrants' experience of interaction with public figures is limited to contexts when their credibility as legitimate recipients of welfare is questioned, and they need to *prove* their right to receive benefits. The perceived stigma of being thought of as a benefit-thief makes migrants defensive towards persons they determine to be strangers. A researcher who is a stranger and potentially a representative of public institutions, thus, is not to be trusted. On several instances I was suspected of being a representative of state agencies, controlling migrants' material well-being and of being able to influence decisions about their welfare payments. For example, a member of the Jewish community refused to talk to me suggesting that I may file an official complain about elderly migrants 'dishonest' practices of getting themselves registered as disabled and claiming nursing care. Another person that I contacted through a non-governmental organisation recommended by the newspaper editor, feared that I might disclose information about his chronic illness to an insurance company. Given such a high degree of distrust, it was almost impossible to

establish direct contact with members of a migrant organisation by visiting their events and introducing myself personally; instead, the sponsorship and support of the informal organisation leader was necessary to gain a degree of trust from its members. Entering the Jewish Community House illustrates this process.

Having first contacted the Chairman of the Community Social Work Department, I was advised by him to meet a Department Officer working with migrant issues. The Officer read my research proposal very carefully and asked me a variety of questions in order to ensure I was not 'spying on their members', as she feared. Perhaps, it was not the ethical statement in the proposal, but my own Russian Jewish descent which convinced her I could be trusted. As a next step she put me in touch with a senior volunteer in the Jewish nursery home and 'a very respected person', according to the Officer. After a telephone conversation with the volunteer, I was invited to the weekly Senior Tea Party at the Community House. Having arrived earlier than the volunteer contact I was almost thrown off the premises by a male community member, who violently insisted that I had come to spy. The volunteer's appearance in a few minutes settled the situation, and I was able to introduce myself to other persons.

The support and help of a Russian-speaking employee in Marzahn Municipal Community Centre (*Quatiersmanagement*) led to six interviews which was more productive than approaches to the Jewish Community House and an NGO run by the newspaper editor. My fruitful cooperation with Marzahn Municipal Community Centre was also assisted by German academics who have already carried out research with the help of this organisation (as I will discuss below).

Approaching migrants through their formal organisation has proven to be a task more difficult than expected. Not only were migrants hard to recruit directly, the snowballing effect was also proven to be rather weak. The interviewees were reluctant to put me in touch with other members of their networks. Perhaps, this unwillingness to participate in research as brokers resulted from the setting in which these persons were initially approached. Evidence collected in previous research (Schoeps 1996; Kessler 2003) and my own experience (as outlined above) suggests that interaction between different groups of members of the Jewish Community is ridden by conflicts and mutual excommunication. The volunteer's authority would oblige these persons to talk to me, but asking their friends to help me would, perhaps, be regarded as imposing a stranger on other persons.

2. Local doctors

Several local doctors with a Russian-speaking patients were contacted as experts (as will be discussed further). Having established a trusting relationship with some of them, I was able to contact some of their patients.

However, given the extreme over-commitment of most of the doctors contacted, only two interviews resulted from this strategy: doctor in Marzahn-based hospital put me in touch with two of his patients.

Formal recruiting strategies had strong limitations and generated a relatively low number of contacts, and making it almost impossible to select matching cases. These difficulties meant that other recruitment strategies had to be found to collect material and, in the event, informal ways of meeting potential research participants proved more fruitful.

Informal methods:

1. Blogging communities

As an active user of the Livejournal platform, I have placed several posts in Berlin-based online communities, introducing briefly the purpose of my research and asking for help. This strategy proved to be quite effective, having generated three replies and resulting in six interviews.

The limitations of this recruitment method pertain to the selective nature of any online community composition. On the one hand, it is mostly composed of younger people savvy in using the internet and, thus, excludes the older generation. On the other hand, it only addresses persons using a particular online service. This limitation, however, could be overcome, to the extent that community members put me in touch with their friends or relatives, who were not necessarily themselves online community members. This strategy permitted the recruitment of non-migrant interview participants: one Russian-speaking blogger put me in touch with a native German household in Marzahn (her close personal friends), who, in return have recommended me to get in touch with their own friends in Charlottenburg.

2. Ethnic entrepreneurship infrastructure: 'Russian' shops, restaurants, leisure facilities, etc.

Recruiting interview participants through 'Russian' services assumed a reliance on help of community entrepreneurs (shop keepers or service managers) and turned out to be most successful, resulting in eight interviews. Initial observations in both neighbourhoods suggested that 'Russian' shops act as community centres, where persons of very different backgrounds can be contacted. Some components of Russian cuisine can only be found

in Russian shops (for example, *tvorog*, a kind of cottage cheese; a variety of pickles and some sweets that were mentioned in interviews), and are sought by migrants regardless of their descent and socio-economic status. At the same time, existing research suggests that ethnic entrepreneurs occupy a position as network brokers in migrant communities (Cohen 1974), and so can be key contacts for getting in touch with a number of individuals (Kapphan 1997). The greatest hurdle in this strategy concerns winning the attention and trust of the entrepreneurs. After three rebuffed approaches (a 'Russian' drug store, a large grocery shop and a tour agency) I established good contact with the owner of a small grocery shop in Charlottenburg and a restaurant manager, running several businesses in Berlin.

Besides contacting ethnic entrepreneurs, I joined a Russian-language yoga course and, was subsequently able to undertake interviews with some of the class participants as well as some of their household members. Contacting people through a Russian-language class excluded all those who chose to avoid such activities and a yoga class is likely to be frequented by persons valuing exercise and so perhaps being more likely to practise other kinds of health-promoting behaviours. Indeed, the yoga-goers and members of their networks were more likely than the others to shop for organic food, believing it was healthy, and to consult non-biomedical healers (as I will discuss in Chapter 6).

3. Academic networks

Six interviews resulted from mobilising Berlin-based academic networks. I identified and contacted scholars who had already carried out qualitative research with this migrant population or in the indicated neighbourhoods (Heusinger 2008; Kümpers 2008), and asked them for help in recruiting research participants. In one case, I was given contact details of a native German family which took part in previous research. The other four cases resulted from contacting a formal organisation (Marzahn Quartiersmanagement) which has helped other scholars to gain access to interview participants. In the latter case no personal details of potential research participants were given, instead, I was assisted in contacting a person who was ready to help me with finding people willing to be interviewed.

The limitation of this recruitment method is quite clear: it only involves persons and organisations who have already demonstrated an interest in taking part in research. At the same time, the benefit of this strategy is that it has permitted to recruit one native German household (and conduct two interviews with its members).

4. Personal networks

Finally, three interview participants were recruited through my own personal networks. On the one hand, such a strategy is limited by socio-economic and cultural bias: persons contacted through my own friends, relatives and acquaintances are likely to resemble myself in descent and identity. On the other hand, relying on the help of my 'native' German contacts, I was able to recruit one participant among non-migrants.

A few serious issues concerning generation and gender roles have emerged throughout the recruitment process. The first interviews demonstrated that for women the provision of help in case of illness is not only a chore, but also a powerful resource to structure family relations and sustain traditional femininity. Provision of home care through the implementation of Russian folk medicines is a tool to sustain gender and ethnic identity and to re-construct 'home' though traditional norms of behaviour. Besides, as mothers or grandmothers, middle-aged women may act as gate-keepers to household members. With these considerations in mind, I focused on interviewing female members of households when it was difficult to gain wider access. Also, if interviewing different generations within one household was not possible, I focused on interviewing their middle-aged members, who experienced migration as adults and also bear the responsibility for the well-being of other family members now. This generational and gendered structure of migrant households also manifested itself in the interviewing process. Initially I was setting out to interview household members separately, expecting that persons would be better able to express themselves in isolation. This strategy however failed in those migrant families where interviews were carried out in the household setting. Whereas members of German households (in different generations) agreed to be interviewed separately in their homes, in migrant families a different dynamic of generation and gender roles prevented individual conversations. In cases when women were contacted as household gatekeepers, they were also present at the interview. Their presence was determined by the setting of an interview as understood by migrant interviewees: a stranger entering the house had to be treated as a guest, with women serving tea and sweets. The presence of other family members seemed to be supportive to interview participants. Insisting on separate interviews would have been inappropriate in these household. Eight interviews with migrants were carried out at their work place or in a neutral setting, like a cafe or park.

Three interviews with female research participants were also marked by the fact of my visible pregnancy, inasmuch it provided grounds to discuss childbirth and childbearing and brought a necessary degree of informality in the interview setting. This focus on birthing permitted me to gather material presented in Chapter 7 of this thesis.

2.4 Lost in translation? Reflecting on cross-lingual and cross-cultural research setting

The cross-cultural nature of this research project is related to perpetual switching between three languages, with interview material being gathered in Russian and German, and written up in English. Hence, translation was an important technique employed both for data collection and data interpretation. The need to reflect on translation from a methodological perspective has been addressed in qualitative sociology (Temple 1997; Birbili 2000; Bradby 2002; Temple 2002; Larkin 2007). They argue that translation inevitably imposes an additional level of interpretation on interview material, and the effects of translation, thus, must be taken into consideration reflexively. The main focus of existing publications is on the role of translator and interpreter in the research process: their relationship with the researcher and their perspective towards material they work with (Temple 1997, 2002). In this research no intermediate figure of a translator or interpreter was involved, with all between-the-languages-work done by myself. Birbili, reflecting on cases where the researcher and the translator are the same person, suggests that the quality of translation is influenced by factors such as: the autobiography of the researcher-translator; the researcher's knowledge of the language and the culture of the people under study, and the researcher's fluency in the language of the write-up (Birbili 2000). In that respect, it is necessary to reflect on my liminal position in the eyes of research participants: a person, whose descent offered a similar background to some potential interviewees, but whose role as a public figure creates distance (Cornwell reflects on interview as a public setting as contrasted to a private setting of a conversation, Cornwell 1984). I speak Russian as my first language so when establishing initial contact with potential interview participants in a German setting, I was identified as a migrant from the former USSR living in Berlin and potentially as 'one of us' or at least a stranger in Germany. Although I would always introduce myself as a PhD student at a British university, most migrant participants were eager to know how many years I had lived in Germany, which status I had and where I came from. My institutional base in another country served as a proof that I was not 'spying' for German officials. The status of my native city within the former USSR rendered me good service: in a long-standing rivalry between the two largest Soviet (and now Russian) cities, Petersburg is often opposed to Moscow as a 'capital of culture', a place where 'real' intellectuals come from. The identity of 'sufferers' attached to Petersburgers since the times of the Nazi siege, makes them treated as a 'special' kind of people. Thus, for the formerly rural-based Russian Germans I

represented a 'refined' person from a big city, without the negative connotations often attached to 'greedy', 'cold' Muscovites. To demonstrate their respect for Petersburg, a few of my Russian German interview participants went as far as showing me old photos of family trips to my native city; whereas others referred to business trips or army service completed there. For the Jewish *Kontingentflüchtlinge* and for self-funded migrants who mostly come from large urban centers I was, instead, 'one of us': a *kulturnij chelovek*, an educated person sharing the values of high culture (a core component of their identities, as I will discuss in Chapter 4). Self-funded migrants categorised me as one of them, too, given that my arrival to Germany was not facilitated by any of the recruitment programs. Independent status, an important component of their identity, was projected on my own history of coming to Berlin, and permitted me to win trust. The fact that I am married to a German also seemed to play a positive role in ways research participants interpreted my biography: for all research participants this choice of partner signified my desire to separate myself from all things 'Russian', an important identity boundary I will discuss in Chapter 5.

Speaking Russian whilst living in Germany has different political meanings to different groups of research participants. The oldest generation of Russian Germans, represented in this study by Erwin and Kristine and by Irma (pseudonyms), experienced direct political prosecution for speaking German in the former USSR. The German language is a part of their martyr identity and a strong link to previous generations: these three persons were socialised in households where only German was spoken, and their spoken German, in their own estimation, is better than their Russian. It must be noted, however, that none of these persons speaks the so-called *Hochdeutsch* ('high German', the standard adopted as the national language), instead, they speak a variety of dialects, ancient in their origins (Hilkes and Kloos 1988; Meng 2001). Whereas Erwin and Kristine requested to be interviewed in German claiming they did not understand Russian, Irma spoke a mixture of languages, switching codes between contexts. These interviews were particularly hard to interpret, given that I do not have a fluent knowledge of these dialects. Hence, only those parts of the interviews which were understandable linguistically were used for analysis.

Self-funded migrants, all of whom spoke fluently high German, did not problematise the choice of language and saw it as natural to be spoken to in Russian. However, a few of them, especially those who had been living in Berlin longer than the others, scattered their accounts with German words. Being bilingual, they switched between codes establishing their identity of persons equally belonging to both cultures (similar issues observed by

Bradby 2002). At the same time, borrowed words in contexts where a Russian equivalent would be readily available, signifies an identity boundary. Given that the German integration discourse was long based on the idea of assimilation (language being a primary mechanism), and that the majority of later migrants speak German poorly, the employment of German words by the early cohort signifies their higher status as 'well integrated' (in contrast to those 'poorly integrated'). The issues of identity boundaries between self- and institutionally-funded migrants will be discussed in more detail in Chapter 6.

As for the latest cohort of middle-aged Russian Germans and Jews, all of them speak German only poorly, and were interviewed in Russian. Certain terms were consistently borrowed from high German by all interview participants: that is, the vocabulary related to nursing care (*Pflege*). None of the interview participants employed Russian (or dialect) equivalents for these words. On the one hand, such systematic borrowing of terminology means that no corresponding structures were familiar to informants in their native setting (as the theory of linguistic relativity suggests (Whorf 1956)). Indeed, when discussing German ambulant *Pflege*, interviewees would mention unavailability of comparable services in Russia. Although the Soviet Union had nursing homes for the elderly and disabled, they were known to be drastically under-equipped and served as a 'trash bins for those persons who no one needs any longer', as one of the interview participants stated. Hence, the Russian term for such an institution, *dom prestarelikh*, is loaded with negative meanings and informants used the German word *Heim* to refer to such institutions in Germany.

Along with persistent use of specific German terminology for addressing nursing care, research participants across different groups employed the Russian word *kul'turnost* (being cultured) to identify themselves. The meaning of this term and its significance for health beliefs and help-seeking behaviours will be addressed throughout the thesis.

Such terms, which have a distinct history, are used in the original throughout the translations, in order to mark out borrowings and definitions which mark identity boundaries and identity transformations.

German is not my native language, so I have probably not developed the same sensitivity to vocabulary used by native informants, as I did in case of migrants. However, given that interviews with native Germans were not the main focus of this research, and were mostly meant to provide with background for comparison, their interpretation is less dependent on linguistic precision.

In order to ensure the precision of translation and to give a detailed account of

translation work, Birbili (2000) suggests back translation or collective translation (carried out in a group of researchers fluent in languages involved). Both options were unavailable to me due to my position as a stand-alone PhD student with limited funding. Hence, unable to do this job, I coded interviews as audio files by means of NVIVO 8 software, and translated excerpts which were coded. In my translation I was not observing the principle of most direct translation. Instead, I relied on the technique of 'creative translation' which does not seek to translate each word by the most direct equivalent, but rather attempts to convey the meaning of the whole phrase, which existing research considers a suitable solution for sociological work, which needs to be 'readable' (Overing 1987; Temple 1997). My intimate knowledge of some aspects of Russian, Soviet and post-Soviet cultures helped me to carry out interviews and translations. However, I tried to avoid assuming that I understood what interviewees meant: for example, one woman mentioned 'all these perestroika difficulties' which I initially assumed to be the era of food stamps and electricity shortages which I have experienced directly. However, as she repeatedly used the term, I prompted her to explain what exactly she meant. Although she was slightly baffled by my query, she gave me a detailed account of life in a Russian village of the 1990s, an experience I certainly could not have imagined as an urban dweller.

Although English is my second language, it is fluent enough to make translations of everyday accounts (which make up the core of material gathered in this thesis). Besides, a long professional experience as an interpreter and translator in various research projects in Russia provided me with a strong background.

2.5 Ethical considerations

The ethical considerations pertaining to this research were approved through the doctoral upgrade process in 2008. Access to members of Russian German NGOs and Jewish *Gemeindehaus* was granted at special meetings by persons occupying managerial positions in these organisations.

All interviews were performed with the full informed consent of the interview participants. To that end, the purpose of the research and the researcher's credentials and affiliation was presented to all potential informants in oral, and, if necessary, in written form. When seeking help from formal organisations, I have addressed them with a brief precis of my research, which I drew up both in German and in Russian. In case of referral from one interview participant to the other, people were sometimes already aware of what the conversation would be about, but I nonetheless made sure that they were willing to participate.

As it is not untypical of qualitative research, providing full confidentiality was not always possible, in particular, when people recommended me to contact their friends or acquaintances, or when interview participants were recruited by formal means. In a family setting, observing confidentiality is also a goal hard to achieve. In that case, informants were aware that members of their social network had participated in research. However, I avoided discussing other people's stories with informants. Cross-references made by members of one family were documented in field diaries, but not discussed in the interviews. Some individual biographical details, such as occupational status or moment of migration, may disclose informants' identity. Where possible, I avoid making references to such details: for example, I have avoided mentioning of migrants' place of origin and tried to disguise their occupation. In some cases, however, this was not possible, given that a profession or place of origin may play a significant role in informants' identities and have an effect on the formation of their health beliefs. For example, coming from Moscow or Petersburg is an important status and an identity marker which can not be disguised without compromising the quality of analysis. In case members of one household expressed controversial reactions to participation in the research, only those who voluntarily agreed were interviewed. In a few households men were unwilling to participate, however, as I would start the conversation with their wife, they would join later, perhaps, feeling the supportive effect of a family setting.

In cases of explicit refusal, if possible, reasons for refusal were recorded. As

discussed above, convincing some members of the Jewish Community of my pure scientific interests and independence from German welfare institutions was especially hard.

Participation in research was solely voluntary and was not encouraged by any formal or informal payments, neither for lay, nor for expert informants. However, gestures of politeness appropriate to a culture studied were considered. For example, when visiting informants at home, I always brought sweets or, in case of a family with a case of diabetes, other 'comfort food', which could be shared during the interview.

Finally, none of the research participants expressed will to be called by their real name; all names appearing in this thesis are pseudonyms.

Chapter 3. Migratory processes to Berlin. Charlottenburg and Marzahn: The Emerge and Structure of ‚Russian‘ Neighbourhoods

This Chapter will introduce the two research sites and the persons who populate them. I will give a brief overview of migration processes which have led to the formation of the two selected Russian-speaking enclaves in Berlin.

In my discussion of migratory processes leading to the formation of several Russian-speaking enclaves in Berlin, I will, on the one hand, look at Berlin as a city of immigration, and, on the other hand, at conditions in the sending countries affecting the composition of different migration waves from the ex-USSR.

To analyse Berlin as a city of immigration, I will follow the analytical structure offered by Brettell (Brettell 1998) in her discussion of the socio-anthropological and qualitative sociological approach to studying migration in urban areas. Thus, the emergence of ‘Russian’ neighbourhoods in Berlin will be discussed in the context of the following issues:

- History of dealing with migrants in Berlin;
- Presence or absence of residentially segregated migrant receiving areas;
- Relationship between the industrial and economic forces and the residential histories;
- Residential policies towards migrants;
- The state of the labour market and ways of migrants' inclusion in it;
- Industry and the urban space;
- Economic conjuncture at the time of the migrants' arrival;
- Presence of an urban ethos that shapes the economic and institutional life of the city and determines the specific attitude towards migrants.

At the same time, discussion of the composition of Berlin's ‘Russian’ communities will include a focus on identity and status components, which, as Vertovec argues (Vertovec 2007), characterise the super-diversity of a migrant population in a modern urban setting. This thesis will not adopt the concept of super-diversity for analytical purposes, given that it had been developed in research of multi-ethnic communities. However, it will encompass aspects, which, according to Vertovec, contribute to formation of migrants' identities:

- Country of origin

- Migration channel
- Legal status
- Migrants' human capital (education, in particular)
- Access to employment
- Locality
- Transnationalism
- Response by local authorities, service providers and local residents

The approach suggested by Vertovec also implies that migrant cultures can not be understood out of context of migratory processes, and are embedded in complex practices of urban everyday life. This line of analysis is particularly important for this thesis, which sets out to understand culture as a composite and perpetually transforming phenomenon.

Following Brettel's and Vertovec's analytical framework, this Chapter in particular, and this thesis altogether, I will analytically desegregate the notion of 'migrants into former USSR' into a variety of distinct group. The analysis of migratory process to Berlin, presented in this chapter, will demonstrate the complexity of Berlin's ex-Soviet immigrant population, and provide a basis for discussion of migrants' diverse identities and health beliefs in further Chapters.

3.1 Charlottenburg

The first thing one sees when approaching Charlottenburg station by S-Bahn (an over-ground subway train), is the Russian tricolor and a word “Россия” (Russia) spelled in large letters at the entrance to the platform. Indeed, for a second one may get confused and have an impression that instead of landing in one of the Berlin neighbourhoods, one has arrived to a Russian town, a feeling which may be amplified by the chit-chat in Russian among other passengers exiting the train.

Having descended the steps, the traveller will see that a supermarket selling Russian goods of all kinds, from groceries to concert tickets, is operating in the station building, and that the word “Россия” is, in fact, a shop-sign. Outside the station a small cafe is selling pirozhki, borsch, shashlyk and other Russian food. Men in trainers lazily sip beer and chat in Russian. Alongside, women with extravagant jewellery and expensive glasses order coffee in German, while hiding their full shopping bags under plastic tables. “Russia” is one of the very few 24-hour shops in the vicinity, and ‘local’ Germans buy groceries there, too.



Figure 4. ‘Rossiya’ shop at the Charlottenburg main S-Bahn station

Welcome to a place also known as Charlottengrad, a Berlin neighbourhood which once used to be the largest Russian book and newspaper publishing centre after Moscow (Schlögel 1994).

Charlottenburg is a neighbourhood located in the south-west of Berlin. The core of its housing was constructed and planned at the end of the 19th and beginning of the 20th century for the city’s better-off bourgeoisie, and since then a reputation of a ‘middle-class’ neighbourhood has been attached to it. This reputation is confirmed by recent research

into the socio-economic characteristics of Berlin districts – the status of Charlottenburg, in terms of its composition and quality of its infrastructure, is among the highest in the city (Bezirksamt Charlottenburg 2004).

The upper end of the neighbourhood is dominated by *Kurfürstendamm* (Ku'damm, as the locals call it), the main shopping street of what used to be West Berlin. It could, perhaps, be said, that during the Cold War, Ku'damm became the quintessence of West Germany. On the one hand, it served as the shop window of the FRG, boasting the greatest achievements of capitalist consumerist culture. On the other hand, massive uprisings against this culture also occurred on Ku'damm, with the 1968 riots sweeping through it. Nowadays Ku'damm remains Berlin's most significant shopping avenue and tourist attraction, flashing banks, hotels, as well as international high street and luxury brands.

The side streets along Ku'damm are largely composed of pre-war, mostly fin-de-siècle housing, with spacious flats, large balconies and sometimes adjacent small gardens. The shopping infrastructure is mostly dominated by luxury boutiques, exclusive beauty salons and confectionary shops. Grocery shops include a few organic brands, vegetable stalls mostly run by members of the Turkish ethnic minority, and supermarket chains. Several weekly markets selling organic and deli food are operating. A well-developed infrastructure of educational institutions is also available, with a few of Berlin's best high schools located there. Charlottenburg is also a neighbourhood with a high concentration of institutions of 'high' culture: The Deutsche Oper (the State Opera House of the ex-FRG) and several theatres and famous political cabarets are also located here.

Thus, Charlottenburg is a neighbourhood with overall high standards of consumerism, both in terms of material and non-material culture. Most of the neighbourhood property is composed of so-called *Altbau* (old house) and a few recently built upper-class new buildings (*Neubau*), which, on the one hand, boast sophisticated architecture and, on the other, are equipped with all modern facilities (such as underground parking and elevators). Old housing in Charlottenburg is also characterised by a supply of apartments with more than two rooms and large floor space, whereas in other old Berlin districts apartments consist of a larger number of smaller rooms (Häussermann and Kapphan 2005: 207). Such apartments are rather expensive, both in terms of rent and ownership, usually being spacious, with a balcony or sometimes even two, parquet floors and ceiling modelling.

At the same time, although Charlottenburg does not have a specific lower end, it does have patches of less attractive housing and shopping infrastructure. First, even most

well-maintained streets have 'touches' of lower-class housing. Due to empty spaces which resulted from heavy bombing in the Second World War, quite a few council projects were constructed in the bourgeois streets throughout the 1970s. Second, there are rather homogenous patches of lower-class housing and infrastructure adjacent to industrial premises, the railroad and several busy streets in the north-east of the neighbourhood. They can be recognised by less attractive (often, council owned) housing, as well as an abundance of liquor stores, sex shops and nail parlours. Housing, as well as shopping facilities within these patches, seems to be dominated by migrant families and businesses, with an overwhelming amount of Chinese, Arab and Turkish grocery and bric-a-brac shops. Several Russian businesses are also noticeable; however, in comparison to other ethnic businesses they are a minority and, in contrast, are located closer to the 'upper-class' core of the neighbourhood. As mentioned before, a large Russian grocery shop is located right in the main Charlottenburg tube station, besides several book shops and travel agencies, a drug store with Russian-speaking personnel and a few restaurants serving food of the former USSR republics operate in the vicinity. A few Russian-speaking doctors also have their surgeries in the neighbourhood.

According to the official statistics of the Charlottenburg-Wilmersdorf Neighbourhood Council (*Bezirksamt Charlottenburg-Wilmersdorf*), persons from the former Soviet Union constitute 11% of all 'foreigners' living in the neighbourhood, making them the third largest group after citizens of other EU countries and Turkey (Leitbild 2008). This evidence, however, is quite vague, considering that these calculations were based on residents' nationality, whereby a number of migrants who hold German citizenship, and so are not included in these statistics. Old West Berlin neighbourhoods have a history of having particular identities, so while Schöneberg is 'gay', Kreuzberg 'Turkish', Wedding 'dangerous' and Zehlendorf 'lavish', Charlottenburg is indisputably 'Russian'.

The first wave of migrants, about 300,000 people from the USSR, arrived in Berlin in the 1920s, being mostly composed of White émigrés fleeing the newly established Bolshevik regime, on the one hand, and the 'Red' vanguard of Soviet Russia posted to Berlin, on the other. A great proportion of them settled in Charlottenburg and adjacent parts of the city. Soon a vibrant community emerged, businesses and schools were started, and an Orthodox church was built. Schlögel argues that the Russian presence had a significant effect on Berlin's cultural life, with Russian cabarets, theatres, galleries and restaurants being opened. Charlottenburg of the 1920s turned into an influential centre of Russian intellectual and artistic life, with such prominent poets and writers as Vladimir Nabokov and Marina Tsvetaeva writing and publishing there (Schlögel 1994). Many of

them addressed migrants' everyday life in Berlin in their literary works (e.g., Nabokov's 'Mashenka' and 'Gift'). Due to developments in German politics and the country's impoverished state, the community dissolved rather quickly, within some ten years, with only a third of the migrants remaining in the city by the mid-1930s. However, the Russian presence remained strong till the beginning of World War Two. By now almost all members of this first Russian community are no longer alive or have moved away from Berlin. None of them was interviewed in the course of fieldwork for this thesis. However, the memory of them is alive and sustained in both academic and public discourse and in narratives of later migrants, as I will demonstrate later: they are often referred to as *Kulturträger*, people producing and preserving culture.

Contemporary 'Russian' Charlottenburg has, in contrast, a very different reputation. Urban legends talk of Ku'damm being crusaded by Russian women in fur coats and dangerously heavy golden accessories, and their husbands driving along in oversized cars, each with a gun on a back seat (Kaminer 2002). In reality, however, modern 'Russian' Charlottenburg is highly heterogeneous and instead of a single migrant 'community' one should rather talk of several 'communities' in the plural, which results from distinct migratory processes leading to their formation, as the next section of this Chapter will discuss.

3.1.1 Migratory processes to Charlottenburg

The formation of today's 'Russian' Charlottenburg started in the 1970s, with persons admitted to the country as political refugees from the USSR settling in the neighbourhood, a great proportion of them being Jewish. To date this migration has been covered by international research only marginally (Heitman 1987; Leshem, Rosenbaum et al. 1989; Fassmann and Münz 1994; Gitelman 1997; Dietz, Lebok et al. 2002). Existing research on migration from the USSR mostly focuses on institutionally assisted migration, both before and after the collapse of the Iron Curtain, whereby, along with Israel and the USA, Germany has been studied as a country accepting members of ethnic minorities recruited by quota regulation: Jewish *Kontingentflüchtlinge* and Russian German *Aussiedler* (Fassmann 1994). There is very little published evidence on those individuals who were legally accepted into the FRG throughout the Soviet era as political refugees, and who can be conceptualised as **self-funded migrants**, given that they needed to overcome all exit and entrance barriers **by their own means**, whereby all efforts necessary to collect information about the receiving country and about opportunities to leave the sending country, all preparations regarding legal and material aspects of migration had to be carried out by migrants individually, and against severe systemic impediments.

Although widely recognised, self-funded, politically motivated migration from the USSR into Germany remains under-studied. This knowledge gap is likely to be due to several reasons. As discussed below, self-funded migration was seen as a form of brain drain. With presumed low numbers (which are documented only poorly) and migrants' smooth integration into the labour market, it has been left unstudied by international migration research, which generally tends to analyse problems arising from unqualified migration. Throughout the Soviet era, research into early self-funded migration from the USSR was likely to be extremely fraught with political tensions of the Cold War, and therefore, perhaps, has been not undertaken for this reason. Thus, no historical treatment of this issue is available and discussion of that early migratory process and its effect on the formation of a community identity in Charlottenburg has to be retrospective and based on anecdotal material.

In particular, I suggest that in order to understand the processes which have led to the formation of the early Russian community in Charlottenburg, the selective effects of the Iron Curtain must be taken into consideration. Two major domestic and international political circumstances have had a significant effect on the composition of migrant cohorts

leaving the USSR for Germany in the 1970s.

First, the exit barriers imposed by the Iron Curtain served as a selection mechanism, with only relatively highly qualified and empowered individuals being able to leave the country. Applying for an emigration permit automatically placed a person and their family in the category of the politically unreliable, meaning almost certain loss of employment and political rights, bullying and stigmatisation (e.g., Shtern 2001). Thus, plans of emigration were concealed and preparations needed to be carried out in great secrecy, whereby a tight social network would become the most reliable source of help. In order to successfully apply for a travel permit one needed to have a good knowledge of the legal framework, both domestic and international, and to be able to survive without stable employment. Emigrants were forced to give up not only their Soviet citizenship, but in many cases also their educational certificates; thus, they were often leaving the USSR without papers, and had to be prepared to take any job in the receiving country. Considering that sometimes preparations and processing of all documents could take months or years, and, in the end might not even result in the successful receipt of a travel permit, and that life in the receiving country was very uncertain, motivation for emigration needed to be very firm, and so was generally based on political, rather than material considerations.

Second, the recruitment process was strongly affected by the mobilisation of the State of Israel, which empowered Soviet Jews with the right to leave the country, making them a privileged group able to slip through the Iron Curtain. For many years an Israeli 'invitation' served as the only legitimate instrument of emigration, with many, actually, going to the Holy Land, and, many others, however, fighting for a choice of destination at later stages of the migratory process. For instance, a transfer in Vienna or Rome, through which all Soviet migrants had to pass, served as an opportunity to apply for asylum in other countries, including West Germany (Leshem et al 1989). Considering the ideological importance of asylum provision in the de-nazified FRG, in most cases migrants were granted it immediately.

The reasons the Soviet migration wave of the 1970s ended up in Charlottenburg are manifold. Residential preferences had been greatly determined by the Berlin Wall, whereby only West Berlin neighbourhoods could be taken into consideration at the time (unlike in times of 1990s migration, as discussed later). Migrants' choices were strongly affected by residentially segregated migrant receiving areas, resulting from housing policies towards 'guest workers' and the state of the city's labour market. Throughout the 1970s a few central West Berlin neighbourhoods came increasingly to be occupied by

Turkish and Italian immigrants (Kreuzberg and some parts of Schoeneberg), who were often legally prohibited from settling elsewhere. Other parts of West Berlin were either highly industrialised and residentially composed of manual workers (Wedding and Reinickendorf) or populated by upper-class families with private villas (Zehlendorf, Steglitz). Thus, Charlottenburg had lower rates of migrant population and, at the time, remained an outpost of middle-class life, offering a lifestyle relatively comparable to what urban Jewish intelligentsia had left behind.

At the same time, the choice of neighbourhood was significantly determined by the proximity of infrastructures supported by the West Berlin Jewish Community, such as the Community House (*Gemeindehaus*), two Synagogues, and a Jewish school. For the early migrants, the Community House served as a main knot in their new social networks, and as a key resource of material and non-material help. Besides, the history of the first 'Nabokov' wave was also well-known to the early migrants, who sometimes knew of the neighbourhood from fiction, and, as I will discuss later, identified themselves with an 'aristocracy in exile'.

The concentration of former Soviet Jews in Charlottenburg has proliferated in the 1990s, when thousands of persons could make use of the 'quota refugee' or *Kontingentflüchtlinge* program, which was developed by the German government specifically for recruitment of the Jewish ethnic minority. Categorisation of Jewish immigrants as refugees in German law is based on the assumption that Soviet Jews had suffered from anti-Semitism, and that Germany, considering its 'historic past' is obliged to provide them with asylum. An implicit purpose of this legislation was to 'revive' the German Jewish communities, which had almost ceased to exist after the Holocaust (Becker 2001; Hegner 2008). Just as in the case of Russian Germans (as discussed further), Jewish ethnicity served as the main (and almost only) criterion for acceptance to the country, whereby religious and political definitions of 'Jewishness' became contested, leading to tensions in the Community and stigmatisation of some migrants as 'fake Jews', as I will discuss further. The Federal Administration Office only started collecting statistical data on Jewish quota refugees from 1993. However, Jews had been coming into the country earlier: before the quota refugee law came into force in 1991 a lot had arrived in the country on a tourist visa, and then asked for asylum. Later they were also given the status of *Kontingentflüchtlinge*. All in all, through the 1990s Germany accepted about 200 000 Jewish quota refugees from the USSR, thus becoming the third main destination for this group of immigrants, after Israel and the USA. This migratory process is crucially different to the one of the 1970s, given its **institutionalised nature**: application for a travel permit

could be submitted in the sending country and a great amount of information about the receiving country was available from different co-operating organisations. Thus, those new migrants can be termed **institutionally-funded**.

The arrival of quota migrants to Charlottenburg is a direct result of the *Kontingentflüchtlinge* migration policies, which made the Jewish Community House located there into a main organisation responsible for the acceptance and support of the newcomers. In particular, Community administration had a very significant role in finding housing, supporting migrants' applications for council flats in Charlottenburg and informing members about available apartments. Besides, the Community House distributes material aid, organises cultural events, operates educational activities and sustains a few nursing stations for the elderly, including a Jewish Nursing Home on the edge of Charlottenburg. At the same time, private resources of help accumulated in the existing residential networks also played a very important role, given that many persons have been reliant on support of other migrants in their cohort throughout the migratory process, or were directly sponsored by the 'established' migrants of the 1970s wave.

The introduction of quota regulation, however, has not meant that self-funded migration came to halt: quite a few 'Russian' persons living in Charlottenburg are self-funded migrants who came to Germany after the break-up of the USSR by different means, sometimes also illegally, and stayed for a variety of private reasons, like education or marriage. Unlike Jewish quota refugees these persons did not receive organised support throughout the migratory process, instead, they had to rely on private sponsorship from persons established in sending and receiving countries alike. Reliance on private capital (in all varieties of its forms) is crucial for this type of migration: In most cases the arrival of these persons to Berlin has been facilitated by members of the earliest, 1970s wave. Examples of such persons are Natasha, who was helped by relatives residing in Berlin since the early 1970s; Sonja, who came to study in the University, being sponsored by family friends well established in the academic world; Oleg, who married a German woman he had met in Belarus; Paul, who first overstayed his tourist visa and, eventually, having legalised himself as a quota migrant, started a grocery business; Lena, who came to study and stayed after getting married to a German citizen. Some of these people, in fact, belong into two categories of migrants. Having arrived independently, they would later use the *Kontingentflüchtlinge* policy in order to obtain a long-term living permit (Like Paul and Lena did). In their case it is important that they came to Germany as independent migrants, being sponsored by their friends or relatives, and embedded into their communities. Hence, their initial social mobility was not determined by conditions of

institutionally-funded migration, as I will discuss in Chapter 5. The residential preferences of these migrants may be explained by the strong role of networks in the established cohort and by the fact that many of them are Jewish: they were recruited from the same segments of the sending society and were integrated into the existing community.

Altogether, Jewish migration, first indirectly empowered by the Israeli ‘invitations’ and then accelerated by German recruitment schemes and by the fall of the Iron Curtain, has led to the arrival into Charlottenburg of different ranks of the former Soviet urban intelligentsia. Jewish immigrants have, in general, high academic qualifications: in Schoeps’ survey 71% of Jewish respondents claimed to have a university degree, with an overwhelming majority having worked in skilled or highly skilled white-collar jobs before migration (about 20% had held managerial positions). Only about 12% of all Jewish immigrants had manual jobs, of which 9.7% were highly skilled (Schoeps 1996: 42). These findings are not surprising, given that evidence gathered in other research suggests strongly that the majority of Soviet Jews belonged to this social stratum in their sending countries (Pinkus 1988; Gitelman 1997). Unlike many Russian Germans, who, as I will discuss later, mostly come from rural areas, the majority of Jewish migrants have not experienced any difficulties adjusting to a large city like Berlin. The post-war history of Soviet Jews is a history of predominantly urban life, concentrated in areas of traditional Jewish settlement: the Southwest of Russia, Belarus, Ukraine, Moldova and the Baltic States. The areas most densely populated by Jews are demonstrated on a map below.

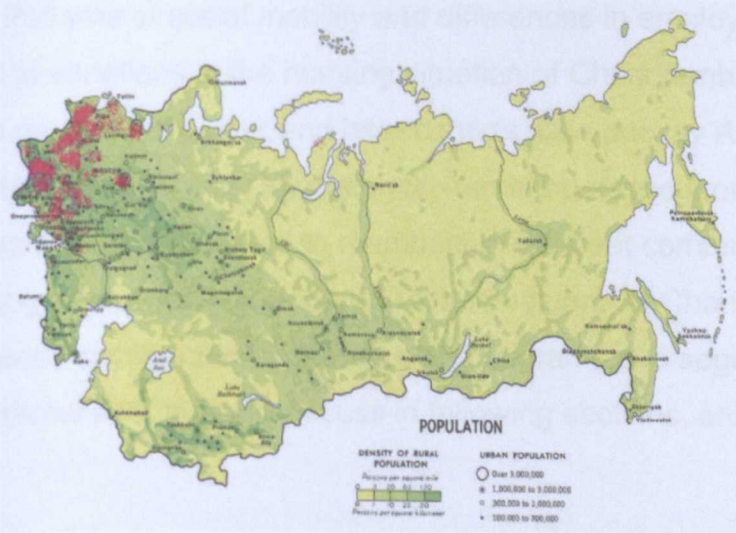


Figure 5. Areas of dense Jewish settlement in the USSR, 1945-1991. Source (Altshuler 1980); FETEC geographical information system http://map.primorye.ru/raster/maps/commonwealth/ussr_pop_1974.jpg last access 12.12.08

The same is true of the latest self-funded migrants. All persons in this group interviewed for this thesis are highly qualified and sometimes even hold academic degrees. The highly qualified character of this migrant cohort is also due to a selection effect related to difficulties in overcoming exit and entrance barriers in the sending and receiving countries. Although the removal of the Iron Curtain has formally empowered persons in the former USSR to travel, their real ability to do so was severely limited by poverty, lack of information and social resources. Only very empowered individuals, mostly concentrated in urban areas and engaging in social networks of higher rank, would be able to gather enough resources to leave the ex-USSR and settle in Germany. Altogether, self-funded migrants are continuously recruited from the most qualified urban population of the sending country, which results, on the one hand, from the composition of sponsorship networks established in the 1970s, and from the type of socio-economic stratification in the sending country, on the other.

In spite of a similar socio-economic background in the sending country, social mobility patterns in the receiving country across different groups of Jewish migrants vary greatly, whereby a strong correlation between participation in a particular type of migratory process and employment situation can be observed. Whereas successful labour market integration is more typical of self-funded migrants, institutionally-funded migrants of the 1990s have significantly more problems entering the labour market and getting a stable income, as will be discussed in the next Chapter.

Patterns of social mobility and differences in employment situations are strongly related to variations in the housing situation of Charlottenburg migrants. Whereas self-funded migrants of earlier and later cohorts alike occupy *Altbau* or *Neubau* apartments in privately owned houses, institutionally-funded persons mostly live in council houses, thus, statuses are visibly marked to members of different communities. Markers of difference are, altogether, hugely important to the structuring of Charlottenburg communities. Identity boundaries constructed to include some migrants and segregate others are both internal and external and, as I will discuss in following sections, are highly complex.

3.2 Marzahn

Marzahn-Hellersdorf is a neighbourhood located to the North-East of Berlin, formerly being a part of the GDR part of the city. Unlike Charlottenburg, Marzahn has a much shorter history of migrant presence. This is only natural, given that the neighbourhood itself is relatively young: Marzahn-Hellersdorf was established in the 1970s in place of several villages as a model GDR urban development project. Within this short period of time, however, several groups of immigrants have settled in Marzahn. According to the communist urban development scheme, Marzahn was to become a model socialist city. Its infrastructure had been carefully planned, and it was to celebrate the triumph of a socialist lifestyle: back in the 1970s, the quality of life Marzahn promised was significantly above average (Häussermann, Kapphan 2005: 214-215). The newly built housing projects had central heating and built-in bathrooms, a luxury unheard of in the old neighbourhoods of East Berlin, where little had been done since the post-war years, with coal-heated ovens being ubiquitous, and shared toilets located on the stairs. Considering that the socialist housing market was strictly regulated, apartments in the newly built blocks were not available on a free market, and were assigned to families faithful to the ideas of socialism and demonstrating a high degree of conformity with GDR political values. In terms of compositional status Marzahn was a very heterogeneous neighbourhood, with persons of very different occupational and educational status receiving apartments there. Those who remained in the decaying old neighbourhoods, especially in areas bordering the Wall, were regarded as dissident, and, indeed, several non-conformist informal organisations were based there (Häussermann, Kapphan 2005). Marzahn came to symbolise an urban socialist utopia, embraced by one part of the East Berlin population, and rejected by the other.

Throughout the GDR years the neighbourhood has accepted a great number of Vietnamese refugees, fleeing political persecution in their home country. Their concentration in the Eastern part of Berlin is still much higher than in the Western, being particularly dense in Marzahn and nearby areas. In the 1990s, following the collapse of the Berlin Wall, the end of the USSR and the German unification, Marzahn has experienced an unprecedented scale of inward and outward migration. Whereas many former GDR families were leaving their flats in the concrete blocks, looking for jobs and better chances in the Western part of the country, thousands of persons from the former USSR were moving in, attracted by cheap housing. Some rough calculations suggest that there are about 15 000 persons from the former USSR living in the neighbourhood now, however,

precise numbers are not available given that the majority of migrants have German passports.

Altogether, rapidly emptying and experiencing increased unemployment rates, in the 1990s the neighbourhood had become a monument to failed political pursuits. Unlike Charlottenburg, Marzahn has become known as a 'bad' neighbourhood. This negative image, however, is not comparable to other 'outcast' neighbourhoods in Berlin, such as Neukölln or Kreuzberg. Whereas the latter have a very high proportion of migrants from Turkey and Arab countries, and often receive public attention in the context of perpetual cultural othering, Marzahn is simply 'drab'. Public discourse suggests that there is nothing 'exciting' about Marzahn, unlike the Western 'bad' neighbourhoods with their 'problematic' Muslims. In recent film and theatre work ('Du bist nicht alleine', 'Cindy from Marzahn', 'Leaving Marzahn') it is depicted as a place of abandoned hopes, populated by unemployed East German proletariat, whose members wear old trainers rather than exotic headscarves, drive old GDR cars instead of dangerously beaten up BMWs, speak the worst form of Berlin dialect rather than incomprehensible Turkish, and drink the cheapest beer possible instead of sweet mint tea. Marzahn is not othered, it is pitied. However, Marzahn should not be compared to the ghettos of large American cities or French banlieus, although processes of de-proletarianisation, criminalization and concentration of ethnic minorities may be observed there (Wacquant warns against such comparisons in 'Urban Outcasts', 2008 (Wacquant 2008)). The infrastructure of services in Marzahn remains very well maintained and developed, and second, compositionally it is still very diverse (Häussermann, Kapphahn 2005: 214).

In spite of the fact that the Vietnamese minority and Russian Germans constitute about 11% of today's Marzahn population (Bezirksamt Marzahn-Hellersdorf von Berlin 2011) it is rarely conceptualised as a migrant-receiving neighbourhood, which can be regarded as an effect of the overall conceptualisation of the migration and integration debate in Germany. The visibility of 'Russians' in the neighbourhood's public space is also less pronounced than in Charlottenburg. Partially this results from the fact that Marzahn in general offers less public space than the 'old' parts of the city: it is a centrally planned neighbourhood with only a few options for ethnic entrepreneurship. Available niches are mostly occupied by the Vietnamese who run small retail businesses, Asian fast food and green grocer shops, with a Russian supermarket located in a much less visible area than Charlottenburg's 'Russia', squeezed in between several high-rise buildings. The supermarket is frequented by all Russian German persons interviewed in this research, however, no 'local' Germans interviewed, when asked, knew of its existence, and no

'Germans' were observed while in the shop. Unfortunately, I was not able to talk to the shop owner to find out whether non-Russians used it. The lesser degree of 'Russian' ethnic entrepreneurship in Marzahn compared with Charlottenburg results from a different composition of migrant cohorts, who come from significantly less privileged backgrounds than Charlottenburg migrants and therefore have fewer resources in starting businesses.

Alongside with the concrete blocks Marzahn has patches of stand-alone private housing, often with garden plots. Some of these houses have been constructed throughout the GDR period, and some are very new. These patches are located on the rims of the neighbourhood; however, they are easily accessible by public transport. Persons in both types of housing were interviewed in the course of fieldwork (migrants and non-migrants alike).

3.2.1 Migratory processes to Marzahn

The overwhelming majority of Marzahn migrants are members of the Russian-German ethnic minority, who have been accepted into the country as ethnic repatriates or *Aussiedler*, and arrived in the neighbourhood during the 1990s. Russian Germans are an ethnic minority, descending from German farmers who have been settling in the Russian Empire since the 18th century, initially invited into the country by Catherine the Great in order to maintain farms on previously uncultivated lands. Throughout the 20th century they suffered greatly from socio-economic and ethnic discrimination at the hands of the Stalinist government. First, Russian German farmers sustained great human and economic losses due to the collectivization policies and the famines of the 1930s. Second, with the onset of the Great Patriotic War, Russian Germans were declared to be 'enemies of the Soviet folk' and were subjected to forced deportations from the Volga region, where they had traditionally settled, into labour camps and settlements in Siberia and Central Asia. Limited in their socio-economic and geographic mobility and deprived of the right to practise their culture, Russian Germans remained severely disadvantaged in the post-war years, as well.

The legal framework which has enabled the re-settlement and naturalization of about 2.5 million ethnic Germans from the USSR dates back to West German post-war legislation. Several laws were issued at that time to enable repatriation of about four million Germans who remained in Central and Eastern Europe after the end of World War Two: Article 116 (§1) of the Basic Law (*Grundgesetz*) issued in 1949; the Expellee and Refugee Law, 1953 (*Bundesvertriebenen und Flüchtlingsgesetz*, or BVFG); and the Act for the Regulation of Issues of Citizenship, 1955 (*Gesetz zur Regelung von Fragen der Staatsangehörigkeit*, or StaReG). Taken together these laws claimed that individuals of German ancestry, or former German citizens who had been stripped of their state membership in Nazi times, could apply for German citizenship and move to the country (Dietz 1995; Sargent 2005).

The law defined Germans remaining in Central and Eastern Europe and Central Asia as *Aussiedler*, – expatriates, – and granted them the right to return. To qualify as *Aussiedler* one had to possess two major characteristics: *Volkszugehörigkeit* - German ethnicity or, if translated directly, belonging to the German people; and experience of discrimination directly resulting from that German ethnicity. At the same time the law

provides that the experience of discrimination must have been universal to all ethnic Germans residing on the territory of the USSR, considering deportations and discrimination applied to them under Soviet ethnic policy (Baraulina 2003). They can apply for German citizenship on the basis of their *Volkszugehörigkeit* alone. Thus, the only criterion for acceptance into the country is the individual's ability to prove their formal ethnic status. To that end, it is important that, considering the discriminatory policies of the Soviet government, many people had concealed or had destroyed all traces of their German ancestry, and so had great difficulty proving their formal *Volkszugehörigkeit*. Others, at the same time, used falsified documents, such as birth certificates or passports.

Discrimination severely limited the chances of geographical and social mobility of Russian Germans, which also led to their inability to leave the USSR during the era of the Iron Curtain. Unlike in the case of the Soviet Jews, there has been virtually no self-funded politically-motivated migration among Russian Germans, in spite of the fact that similarly to Israel, Germany was putting pressure on the Soviet government to acknowledge its repatriation laws. Only about 100,000 people managed to leave the USSR to Germany under this policy arrangement between 1950 and 1987 (Dietz 2000: 637). Permission to leave the USSR was only available to those who already had relatives in the Federal Republic and, on the basis of the bilateral agreement between the FRG and the Soviet Union, could apply for family reunification. Once perestroika started, more people wishing to reunite with their families or move to the country of their ancestors were granted permission to leave, and were admitted to Germany. About 160,000 Russian Germans left the USSR between 1985 and 1990. After the Soviet Union ceased to exist, emigration from its former republics dramatically increased: about one million people left between 1990 and 1995. This can be explained by the fact that the repatriation initiatives of the Kohl government (Kurthen 1995) coincided with a political, social and economic crisis in the ex-USSR. The graph below demonstrates this trend.

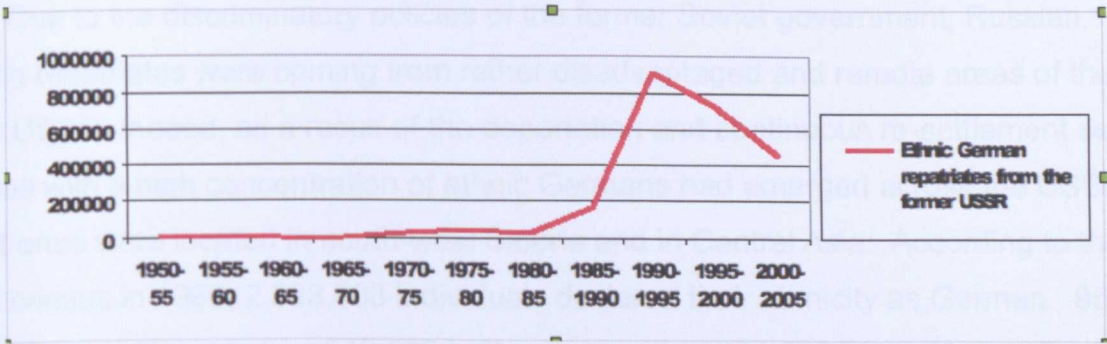


Figure 6: Repatriation of Ethnic Germans from the USSR, 1950-2005. Source:

The migration dramatically increased in 1987, reached its peak in the early-mid 1990s and started to decrease gradually from the end of the 1990s. In 1986 only 753 persons left the USSR to Germany as Aussiedler. In 1987 their number grew immensely, more than twenty-fold: there were 14 488 people. In 1988 it was already 47 572 people. In the mid-1990s about 200 000 people were entering Germany annually.

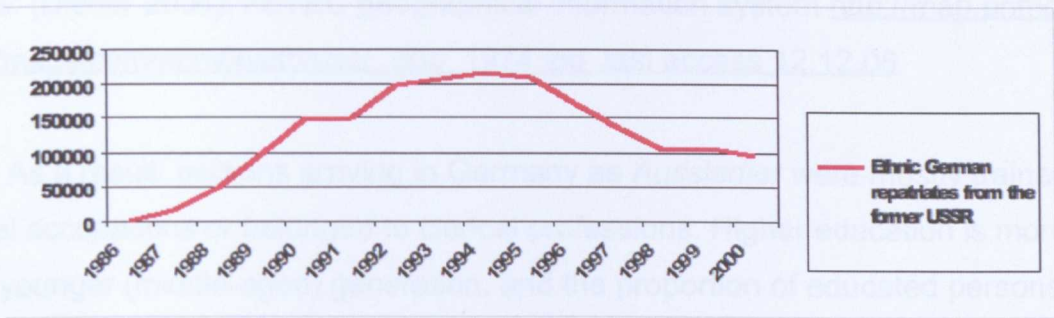


Figure 7: Repatriation of ethnic Germans from the former USSR, 1986-2000.

Source: Bayerisches Staatsministerium für Arbeit und Sozialordnung, Familie und Frauen. Statistik SpätAussiedler und deren Angehörige September 2007.

1991 was the year when the nature of the re-settlement changed from individual politically motivated persons to frustrated masses. The old order was gone, and an overwhelming feeling of insecurity swept through the former USSR republics. Unemployment and poverty was escalating, the safety nets had collapsed leaving people without pensions, welfare benefits and basic healthcare provision. An opportunity to leave for Germany, regarded as a country with a stable economic and political system, was the ultimate chance to provide the family with better chances and, sometimes, simply to survive. Those who would not have considered leaving the country before started packing their suitcases.

Due to the discriminatory policies of the former Soviet government, Russian German repatriates were coming from rather disadvantaged and remote areas of the former USSR. Indeed, as a result of the deportation and continuous re-settlement several localities with a high concentration of ethnic Germans had emerged across the USSR. The largest ones were located in south-west Siberia and in Central Asia. According to the last Soviet census in 1989, 2,083,603 individuals declared their ethnicity as German. 957,518 of them lived in Kazakhstan, 842,295 in Russia, another 101,309 in the Kyrgyz Republic,

39,809 in Uzbekistan and 32,671 in Tajikistan (Dietz 1995: 35). The areas most densely populated by Russian Germans are shown on a map below (marked by the red colour). This map also suggests that from the well-developed Volga region Russian Germans were pushed into the less populated areas of the USSR, with highly dispersed urban centres. This geographical location has caused not only ethnic-based, but also regional inequalities in access to education, employment and culture.

Figure 8: Areas of dense Russian German settlement in the USSR, 1945-1991.

Source: (Diener 2004); FETEC geographical information system http://map.primorye.ru/raster/maps/commonwealth/ussr_pop_1974.jpg last access 12.12.08

As a result, persons arriving in Germany as *Aussiedler* were mostly trained in manual occupations or belonged to clerical professions. Higher education is more typical in the younger (middle-aged) generation, and the proportion of educated persons is lower than among Jewish migrants. The high concentration of Russian German *Aussiedler* in Marzahn may be explained by several factors related, on the one hand, to formal restrictions in access to housing, and, on the other, to the gradual emergence of residential networks. According to the practice of Berlin housing agencies, in order to obtain a permanent rental contract, one needs to present documentary proof of one's ability to pay. This capacity can be guaranteed by several means: individual income; external private sponsorship or welfare-based sponsorship. External guarantors support of migrants' reliability serves as an issue further determining the area and density of migrants' residence. The Jewish Community supports migrants' applications to council houses in Charlottenburg and adjacent West Berlin neighbourhoods. Russian Germans receive no extra institutional support in seeking housing and are reliant on their personal networks only, in many cases searching for housing together with other persons from the transition camps they stayed in. The availability of cheap property in Marzahn, the readiness of local agencies to accommodate migrants in concrete blocks with otherwise shrinking populations, and a wish to maintain geographical proximity to members of social networks that develop in transition camps, have served as the greatest determinants of residential preferences in the 1990s.

Having obtained permanent housing and having acquired a legal status, Russian Germans are formally able to enter the labour market freely. Such smooth institutional transition, however, exists only on paper. As I will discuss in the next section of this



Chapter, a great proportion of *Aussiedler* suffers from long-term unemployment, unable to get their qualifications recognized by the German authorities, and having to rely on social welfare or semi-legal jobs. A few cases of successful entrepreneurship in Russian Germans have, however, also been included in this thesis: Victor, a psychiatrist with a private consultancy in Marzahn; and the Kaisers, who run a Russian-speaking leisure club (Galina) and a small transport company (Sergey). Both households, in spite of great differences in composition (Victor is single, whereas Galina and Sergey have four children), occupy the same type of housing: they live in private houses, having long ago left the concrete blocks. Thus, similarly to Charlottenburg, internal socio-economic variations can be observed in Marzahn.

Summary

This Chapter has demonstrated that the composition of the ex-Soviet migrant population is highly heterogeneous, resulting from various complex successive and simultaneous migratory processes. Migrants were recruited from very different segments of the sending society, whereby variations in socio-economic, regional and ethnic backgrounds suggest differences in identities persons have acquired and developed throughout their lifetimes.

The self-funded migration of the 1970s-1990s can be characterised as chain migration. Upon settling in Germany each new generation of migrants would facilitate the arrival of further generations by recruiting people from their own social networks. Thus, participation in migratory process was limited to people of particular social class and particular ethnic background, and was greatly facilitated by informal support. Processes of chain migration, mostly involving urban intelligentsia, have led to formation of the ‚Russian‘ infrastructure in the West of Berlin, to emergence of different forms of ethnic entrepreneurship, and to establishment of generation identities.

Due to German institutional practice and policy making, the migration of the 1990s and early 2000s took shape of facilitated diaspora migration. Recruitment and acceptance policies were developed with the purpose of letting two distinct ethnic groups, the Russian Germans and the Jews, to settle in Germany. Indeed, migratory processes often involved extended families or whole villages. However, we must bear in mind that for the majority of people involved in these processes, actual re-unification with its own ethnic group was a motivation, significantly weaker than economic considerations. The graph, presented on page 93 demonstrates the relationship between worsening of material situation in the former USSR, and the influx of migrants into Germany. Max Frisch, a Swiss writer and public intellectual, has coined a famous phrase about the arrival of Turkish labour workers into Germany: ‚We invited workforce, but those were people who came‘. In case of institutionally-funded migrants one could say, that ‚We invited members of German and Jewish diasporas, but there were economic migrants who arrived‘.

Hence, the population of migrants from the former USSR in Berlin is, indeed highly heterogeneous. These persons have been recruited by different channels, and are very unfamiliar to each other in terms of religious, ethnic, socio-economic and other characteristics. Their legal statuses in the receiving country also vary, depending on the type of migratory process they had taken part in. Moreover, given important and very rapid developments in recent German history (re-unification and merge of the two previously

separated parts of Berlin) and related changes in the political climate and the labour market, persons arriving in the country at different times have had very different opportunities. Today's Berlin ,Russian' population includes groups of ,expats', that is, highly qualified professionals working abroad; former political asylum seekers; and recent economic migrants. Those significant differences in all aspects of migrants' lives suggest that health beliefs of persons studied in this thesis will also be characterised by extreme complexity and will be anything but homogenous.

The next Chapter will explore the genealogy of migrants' health beliefs and help-seeking practices by looking at conditions under which different groups of migrants have been socialised. In particular, I will focus on the effects that the stratification system of the sending country had on migrants' identities, health beliefs and ability to seek help. I will demonstrate that, similarly to every other developed society, in Russia (and other successor states of the former USSR), socio-economic status is a strong determinant of health beliefs and help-seeking practices. The next Chapter will demonstrate that over-generalizations about ex-Soviet people as altogether 'passive' and 'unable to make decisions about their health', popular in some literatures, are, at best, superficial. Instead, I will demonstrate that migrants belonging to different strata of the (post) Soviet society have developed different health beliefs, with education, regional inequalities and types of family playing most significant roles.

Chapter 4. Genealogy of health beliefs. SES gradient and Identities: Experience in the Sending Country

This Chapter will place migrants' health beliefs and help-seeking practices in a biographical perspective. I will analyse the effects of socio-economic stratification and cultural differentiation in the sending society on migrants' beliefs about health.

In their extensive research, Ludmila Panova, Nina Rusinova and Julie Brown (Brown and Rusinova 1993; Brown and Rusinova 1997; Rusinova and Brown 2003; Panova and Rusinova 2005) found that education and occupational status serve were key characteristics in understanding the help-seeking behaviours of different groups of the (post)Soviet population. A broad network of informal services and 'economy of favours' (Ledeneva 1998; Lonkila 1999) which was relied upon in all spheres of everyday life, was crucial for people's ability to get help, including health care. Considering that the socialist economy of shortages and income rationing created a virtual inability to convert material capital, it is necessary to take into account the immense role of social capital and informal networks in (post)Soviet social stratification (Rose 2000; Clarke 2002; Rose 2003; Ledeneva 2006). Thus, inequalities of opportunity resulted not from incomes, but from unequal inclusion into private networks of different range, providing informal access to scarce or fragmentally distributed resources.

The effects of socio-economic stratification on help-seeking behaviour are exacerbated by regional inequalities across the former USSR, whereby Central Asian republics, when the majority of Russian Germans have been recruited, had the worst living and working conditions, as well as the least equipped medical facilities with the least qualified personnel (McKee, Healy et al. 2002; Balabanova, Falkingham et al. 2003). The post-Soviet neo-liberal reforms have further contributed to these inequalities, leaving the socio-economic structures of these new countries, including their healthcare systems, virtually on the brink of devastation (Field 1995; Burger, Field et al. 1998; Field and Twigg 2000; Garrett 2001). A similar situation has been observed in Russian and Ukrainian rural areas and small towns which have been continuously stripped of investments and experienced an escalation of poverty in the 1990s (Kay 2011). Thus, persons in these areas have suffered badly from the overriding lack of resources, being hit strongly by unemployment and the collapse of the safety nets in the transitional period, and were unable to substitute for organisational drawbacks by means of their private networks: the resources were simply not there.

Keeping in mind those structural conditions, the research participants may be organised in three unequally empowered categories of help-seekers:

The Privileged are the individually funded and the Jewish quota migrants. Being recruited from the stratum of the established urban intelligentsia, these persons were able to rely on a significant amount of social capital, whereby one of the decisive factors was their ability to participate in inter-generational transfers. They were able to employ the greatest range of help-seeking practices, which resulted from their ability to receive necessary help by mobilizing their private networks. Their networks, as I will discuss below, included highly qualified medical professionals, and they were able to successfully by-pass institutional gatekeepers, such as local polyclinics, in their search for help.

The group of **Fragmentally Empowered** consists of urban Russian Germans, with one exception of a Jewish asylum seekers family from a Moldovan city. Unlike the individually funded and most Jewish migrants, the majority of urban Russian Germans are persons who have achieved upward social mobility in one generation and have moved to the city from a rural setting (this may be explained by the discriminatory policies applied to the post-war generations of this ethnic minority, as discussed in the previous Chapter). Some of them belong to first-generation intelligentsia, and some to the stratum of skilled workers, but none was born to parents with higher education and was able to rely on established social networks. Those persons were much more strongly reliant on institutionalised forms of care provision, such as district and workplace polyclinics, as well as commercial services. Their networks mostly consisted of lower-ranking medical professionals, such as nurses, pharmacists and ancillary personnel, and were significantly less extensive. Thus, the experience of this group is quite uneven, whereas in some cases they were able to receive help they needed; in others they faced neglect and poor treatment.

And, finally, the group of **Disadvantaged** consists of persons recruited from rural areas, who are, without exception, Russian German. On the one hand, the majority of these persons belonged to the manual classes, both skilled and unskilled. Their social networks were too limited to access help by by-passing institutionalized care providers. On the other hand, the condition of rural healthcare facilities was so drastic that reliance on their assistance caused nothing but disappointment.

It must be kept in mind, that this research is not setting out to present an objective view of the state of post-Soviet health care (which was very uneven). Instead, I will focus on migrants' subjective opinions and interpretations of care they were able to receive. Their accounts are not necessarily 'accurate' in description of the services, however, they

provide a rich material for understanding of people's own beliefs about 'proper' care and 'proper' ways to stay healthy.

Research demonstrates that higher levels of education and better income are related to a more 'pro-active' approach to understanding of one's role in health maintenance, whereby determinants of health are 'internalized' and the individual is regarded as responsible for his or her health (Blaxter 1990). Lower levels of education and lower income, by contrast, are related to understanding of health as a product of external factors over which one has less influence.

Nonetheless, it would be a great overgeneralisation to suggest that 'all poor and uneducated' persons are fatalistic about their health, whereas 'all rich educated' ones act as autonomous agents. Instead, when making sense of health and illness persons manage a complex understanding of external and internal factors affecting them, and to do justice to this complexity we need to understand health in people's own terms.

Two concepts emerged in this research as particularly important to understanding of 'external/internal' health beliefs dilemma: *kul'turnost* (культу́рность - being cultured) 'takaya zhisn' (life how it is').

Kul'turnost makes up the core health belief of persons who have previously belonged to the categories of 'privileged' or 'fragmentarily empowered' in their sending country, as well as in accounts of a formerly 'disadvantaged' family with higher education from rural Kazakhstan. In their accounts of a 'cultured' approach to health, *kul'turnost* has two major functions: pro-active pursuit of knowledge and resources for implementation of this knowledge, on the one hand, and segregation of 'others' into categories of 'uncultured', on the other. In the interview material I have collected, both components are expressed with respect to health.

The concept of *kul'turnost*, which refers to the ability of an individual as an autonomous agent to affect his or her health, is intricately related to the notion of 'takaya zhisn'. It is hard to provide with a singular translation, equally accurately delivering the meaning of this expression in all contexts it is being used. The most direct translation of the expression migrants use would be 'that is how life is', however, in some contexts should rather be formulated as 'taking life as it is'. In order to avoid distortions in interpretation, I would avoid translating 'takaya zhisn' as 'fatalism'. As I will demonstrate throughout this thesis, 'taking life as it is' does not necessarily imply a fatalistic approach. Instead, 'takaya zhisn' embraces migrants' understanding of the structural empowerments and the constraints which determine their lives. 'Taking life as it is' refers to theorisation of circumstances which seem to be objectively affecting one's health. Understanding of

health in these terms is more typical of the formerly disadvantaged persons, although it also pertains to the conceptualisation of particular health determinants in fragmentarily empowered and privileged groups.

The following three sections of this Chapter will examine the genealogy of health beliefs in all three groups in closer detail. On the one hand, I will look at socio-economic and regional inequalities as strong determinants of migrants' objective ability to seek help. On the other hand, I will focus on family structures and identities as pre-requisites of migrants' subjective perception of health and their ability to maintain it.

4.1 The Disadvantaged: Rural Russian Germans

A degree of fatalism with respect to health and the unavailability of medical care in the former-USSR was especially pronounced in the manual classes and persons with no history of higher education in previous generations (Brown and Rusinova 1997, Rusinova and Brown 2003). These class structures are amplified by regional inequalities: persons in rural areas or in places suffering from post-socialist de-industrialisation became disempowered in their ability to access even the most basic medical help (Garrett 2001, Kay 2011). Poverty, directly experienced or perceived by these people, would also prohibit them from utilising commercial medical services. In such households choice with regard to health and management of illness episodes grew increasingly embedded in the informal context, as one could only count on care provided by family members and uncertified folk healers. Tradition, especially with respect to the distribution of gender roles in caregiving, gained significant importance and in some cases turned into a substitute for technology and expert knowledge. These persons can be categorised as **disadvantaged**. Of migrants interviewed for this thesis, several Russian German households in Marzahn, coming from rural Russia and Kazakhstan, six belong to this category. In spite of differences in educational attainment among them, all of them conceptualise the effects of life in their sending countries on health, as negative.

Albert and Nina:

It is just all that hard work we did all our lives, how can we expect to be healthy now? (Nina shows me her swollen legs by raising a long skirt up to her knees - P.A.): I worked in the field all life long, then we were building all the time, there was construction work, there were four children to take care of! One day you just can not do it anymore. You are old.

Albert adds:

Yes, life was very, very hard, work dusk till dawn. We are squeezed like lemons now. What can you do about it? Nothing!

Kristine (Erwin's wife):

Oh, my dear child, you don't want to know what we went through. War, war is the worst, starvation, we had nothing to eat! I had to gather grass in the fields to feed my younger siblings, and we were lucky if we could kill a squirrel every

once in a while. It was very hard. And I worked all my life, I carried all these heavy buckets with porridge and soup [Kristine was a cook]. This is what life was. What kind of health can I have now?

Higher education did not mean alleviation of the daily burden by means of different work. In retrospect, formerly rural-based persons with university degrees speak of their health as fully determined by life itself, which needed to be 'taken as it is' (takaya zhishn):

Marina:

So, how did we live in Kazakhstan? We lived in the rural area. There you get up in the morning and do your first shift in the barn or in the garden. Then you go to work. Then, you come back and go back to the barn, to run your household. Same on weekends. So, music, dancing, painting, that was not for us. (...) And health-wise... Take a cat-skinner, for example. All day long he sits there and swallows dust. In winter it is very cold, in summer, very hot. This all has its effects... No protection, no resort vacations, nothing. And then he goes back home and continues to work in his own barn.

Petr, her husband, adds:

Given how old I am [46], it is time for me to pack up. We come from such a zone of Kazakhstan where a lot of radiation was around, missile testing, and so on. Take our relatives. With them, old age would start before sixty, and by sixty three they would die. Very few people would make it up till pension age. Everybody was living in villages, which means you work dawn till dusk. That is how it was.

Ludmila, who has recently survived a devastating car accident and is severely limited in her physical capacities, looks into her past in a village in the south of Russia with genuine horror, for which, she, perhaps, has a good reason:

I would not survive there, no chance. What kind of life did we have there? You must go to work every day, right? So, in the morning you go to the factory. And then, after hours, you take care of your household. You feed, clean and milk the cattle. You work in the garden. And in the autumn you also must go to the market and sell your stuff, because you will not survive otherwise. There were no wages paid, that's it! And, I mean, we were living a life someone would call 'rich', we had a car and we were even able to buy a computer. But there was no minute of rest, never. Who would take care of me there? And in winter the roads were blocked by snow and you could die crying your guts out, no doctor would

ever come. There was one GP for two villages, what could he do? Give you a painkiller?

The experience of getting any medical care was also traumatizing for these persons. Of giving birth which occurred for her in the hospital of a local town, Marina says that 'no German woman would survive it'. She summarises her experience of getting help in a local healthcare network as follows:

Everyone was so rude, so loud, they were commanding you around all the time. You would come there ill and walk out even more ill.

Under conditions of severe disadvantage, family becomes the main realm of help and support. Unlike urban Jewish migrants, Russian Germans mostly talk of family ties and relying on tradition when reflecting on who they are. Indeed, at the core of Russian German identity is one's position in and reliance on the extended, multi-generational family. An excerpt from an interview with Ludmila demonstrates this observation. After I turn on the recorder, she starts introducing herself in the following way:

In fact, I am not German. I am Russian. My husband is German, and we have spent more than 25 years together, so that I consider myself to be a part of the German folk, too. That is because we have very strong relationships within his family. I mean, not just me and my husband, but the wider family. All relatives, everyone, always support each other, we have very close relationships. I feel a part of them, all these people, altogether they are may be fifty persons. And with this big family I have closer contact than with my own. So, I consider myself Russian German.

The quality of family relations is expressed in the ability of a household as a whole and each member individually to cope with *common work*. Relationships with children and parents and between siblings are discussed in terms of *doing* things: a good family is a family where people help each other with mundane chores and *where everyone is coping with difficulties together*, thus, caring for each others' well-being. In that respect, fixed generation and gender roles are highly important. Ideally, a Russian German family is willing to maintain a structure Margaret Mead calls *post-figurative* (Mead 1970): children learn from parents, and experience and knowledge is transmitted from the oldest to the youngest. Erwin and Kristine also tell me about their whole extended family, referring to

how everyone was helping them with renovation: their son was doing the shopping, one nephew was putting up the wallpaper, the other nephew did the ceiling, and, altogether, everyone took their part.

In fact, it is Russian German households where I was invited to look through family albums or pictures of family members proudly hanging on the walls: Irma, Emma, Erwin and Kristine, Ludmila, Albert and Nina all showed me proudly pictures of their relatives, telling stories about them and stressing how helpful they have all been one time or another. In comparison, only in one Jewish household was I shown a family album, too: Tamara, who is a grandmother of a close personal acquaintance, wanted to demonstrate my friend's likeness to a great-grandmother. Similar references to family as the core of Russian German identity have been observed by Clark in her study of the life of this ethnic minority in the modern USA (Clark 2011).

A post-figurative family, according to Mead, is usually based on three generations living together, which is the household structure the rural Russian German migrants I have spoken to socialised in, and which they consider to be 'natural'.

Ludmila, when reflecting on the German system of nursing homes for the elderly says disapprovingly:

The way we are brought up is that we live together with our parents. Everybody wants to live in a family of course. Not with people of their own age, but with other generations. Maybe, it does not have to be the same flat. But, for example, my son has just moved out, he has his own family, but he comes and visits every day. That he moves out does not mean he has left us alone. I am just saying, all generations have to live as a family, with each other. For example, my grandma died in the family. The other grandmother, too. My father-in-law, he also died in the family. And my mother-in-law, now, in Germany she has a separate apartment, but everybody visits her every day.

Petr and Marina express similar opinions when discussing their family lives. Petr, for example, says:

I got used to the fact that Grandma lived with us. She had her own place, a mud hut, but my parents, they built a new house. And it was clear to everybody in the village, why, I mean, everywhere in the USSR it was clear as day to people that older people belong to the family. There were no old people's homes, the elderly were a part of the family.

To a great extent, such family structure was necessary to cope with extremely hard

material living conditions (Petr's mention of his grandmother's mud hut, for example). When reflecting on their lives, most of the persons develop a narrative about working hard against all odds, whereby physical and agricultural labour is reflected upon as a traditional occupation one takes up without 'whining'.

Ludmila:

I had no idea that when a person is ill they may count on some help. Because we had to survive. It was perestroika times, it taught us to endure anything. What have we not done! Grew our own vegetables, tried to have a business, worked, everything. There was not a single minute to take a breath. In summer, you would do preserves all the time, because otherwise you would have nothing to eat in winter. When we left, I think, I had at least five hundred jars in the barn. It was survival!

Marina:

With us it was like this. In the morning you have got your first shift, in the garden. You dig your potatoes, do errands in the barns, things like this. Then, you must go to work. Eight hours there. Then you come home, and the barn shift starts again, and, besides, you must feed your children.

Emma:

We have always worked very hard, never sat with our hands folded. We had to maintain a house, some poultry and a garden, that was permanent labour, all the time.

In post-figurative families and cultures, as Mead suggests, the role of the older people is especially important in transmitting those images of never surrendering heroes. The oldest generation which still has memories of deportations identify themselves strongly with a role of tough survivors. These people express fears of discrimination and war.

Kristine:

I always say, mein Kind, I fear nothing, only hunger. I have seen hunger, and I know what I am talking about. When everyone has no teeth, and they swell all over, and then they die, because no one can walk anymore and bring them a bit

of water or some potatoes, it breaks your heart. I survived because I was very lucky! A girl died in a village, and I got to keep her valenki , they were just my size. Was I happy! No one else had valenki! When winter came, I picked wood in the forest and brought it into the village, and people gave me a bit of bread or milk. No, I can't complain, everybody treated us very well, they were proper people.

Albert:

I am only afraid of environmental disasters. Everything else we have survived, war, suppression, we have survived and live on. I just do not like turning on the TV and seeing things like Haiti, for example. And then they say, the same can happen in Berlin if the climate change does not stop. It makes me very worried!

Mead suggests that persons who have socialised in post-figurative cultures see their lives and identities as pre-determined (Mead 1970: 5):

The answers to questions: Who am I? What is the nature of my life as a member of my culture; how do I speak and move, eat and sleep, make love, make a living, become a parent, meet my death? are experienced as predetermined. It is possible for an individual to fail, to be as brave or as parental, as industrious or as generous, as the dictates which his grandparents' hands conveyed to him, but in his failure he is as much a member of his culture as the others are in their success.

Margaret Mead suggests that a post-figurative culture is one in which change is so slow and imperceptible that grandparents, holding newborn grandchildren in their arms, can not conceive of any other future for the children than their own past (Mead 1970:1). Certainly, Russian Germans of the ex-USSR who were involved in industrial labour in institutional structures of a developed, modern society should not be compared with traditional societies, where post-figurative culture is preserved in its most uncompromising way. However, given that repressions and discriminations to which Russian Germans have been subjected for several decades, they have become a shared experience for several generations. Years of severely limited social and geographical mobility have made change almost imperceptible.

Petr, a Russian German man of 46, a father of two children, says:

With us, it was like, we lived very ordered lives there, I mean, this is just how things were done, how it went. If you are a guy, then you must go to school, and after you finish school you have to go to the army. If you don't go to the army, that means you are sick or crooked in some way, I don't know, girls would not look at you. After coming back from the army, you would get married, start a family. All how it should be! So, by the time you are 45 your children would already be old enough, like 22-23 years old, and you would have a bit of your own life. (...) By 45 you are an adult, mature man. You have reached some goals, got an education, done your military service. And if you have had a normal, proper, life, you can start thinking of the future.

This general feeling of pre-destination manifests itself in the ways Russian German persons from rural areas conceptualise health. In interviews with persons who came from rural areas and belonged to manual classes in their sending countries *'taking life as it is'* is usually placed in a context of permanent hard work and suffering.

Petr:

We would not think much about health back in Kazakhstan. Was too much work to be done. That is what life was there [такая была жизнь]. (...) And you know, it was like a post-war zone there, anyways. The Germans had in the 1940s, and we had it back then. All was destroyed, no medical help, nothing available. The salary would not be paid for months.

Ludmila:

There was no time to take care of yourself in Russia. It was hard work dusk till dawn, but also, even if you had money, what would you do with it? The air, the soil, they were poisoned. You could not get normal food anywhere. There was no water.

Hard labour, discrimination and war are conceptualised among the persons who were most disempowered in their sending countries as the strongest and negative determinants of health, against which nothing could be done. Their understanding of their future and their ability to remain in better health is strongly related to past experience: Albert, Nina, Erwin, Kristina and Irma all wish themselves nothing but 'peace' and that 'everything remains the way it is'. To them, Germany is 'the world of plenty', and being able to enjoy it is regarded as the strongest positive health determinant.

Having arrived in Germany, many of these people will feel overwhelmed by the sheer material well-being the new life, they will take as it is, will offer to them. Some of the younger members of this group who also have higher education, that is, Petr, Marina and

Ludmila, will see migration as an opportunity to engage with a more pro-active approach to health. As I will discuss in Chapter 7, their satisfaction with German healthcare is rather strong, as well.

4.2 Fragmentarily Empowered: Urban Russian Germans

The group of the Fragmentarily Empowered consists of urban Russian Germans and institutionally-funded Jews who came from less developed urban areas of the USSR (mid-size towns in Ukraine and Moldova). On the one hand, this categorization may be attributed to the socio-economic status of these persons: urban Russian Germans belong either to first-generation intelligentsia, or to a stratum of skilled workers and clerks. Jewish family in this category, Julia and Joseph, also belong to this stratum. Resulting from these qualifications, their working conditions would be less related to hard manual work than those of the people in villages. On the other hand, urban life also meant an improvement in housing and less effort required to maintain a household. At the same time, access to medical care and other goods necessary for health (first and foremost, nutrition) were restrained. Unlike the most privileged group of persons (as discussed further), the fragmentarily empowered could only partially substitute for the gaps in the state's safety net by means of their private capital.

The status of persons in this category was determined by the limited amount of social capital at their disposal, so that their main help-seeking strategies were centred on institutionalized forms of help provision, such as district polyclinics and hospitals, workplace medical facilities and commercial clinics. Similar patterns have been observed in manual classes and first-generation intelligentsia by Rusinova and Brown (Rusinova and Brown 2003), who suggest that the majority of persons without established networks needed to rely on official pathways into the system and would enter medical institutions without protection, which often led to disappointment with care.

These persons were seeking help very pro-actively, but they were unable to locate all resources which were necessary to them. Unlike the disempowered persons in the rural areas, they felt more control over health and developed an understanding of health as an independent virtue and achieved status. For example, Emma tells a story of neglect and disrespect during gynaecological treatment, which, unfortunately, is widely documented as typical for many Soviet women (Rivkin-Fish 1997; Rivkin-Fish 2005; Temkina 2008):

I went to Alma-Ata to study. And when I arrived I realized I was pregnant. I was sick all the time, I could not do anything. But I had to concentrate, to learn! I needed to. So, I decided to have an abortion. It was about a month and a half. And this doctor, I think she has damned me [proklyala menya]. She just detested me and grumbled, 'all of you, you all just want one abortion after another! No one wants to have children! I wish the government had forbidden

you that. Have three children and then go and have abortions!" May be she is right, actually... But she scraped everything inside me so badly, that I was never able to get pregnant again.

Mikhail and Larissa told of their experience seeking help from district healthcare services when Mikhail was diagnosed with diabetes. Their case was also characterised by neglect and disempowerment:

There was simply no point going to the polyclinic. First, it was impossible to get an appointment with an endocrinologist. Then, finally, when we made it, he said: Well, what do you expect at such an age [Mikhail was over 65]? We will not treat him, he is too old.

Continuous efforts to arrange treatment faced shortages in the healthcare system:

There was no insulin in the Ukraine, nowhere. In the black market, maybe, you had to hunt for it, and pay for it from your own pocket. So, there was basically no treatment available, the hospital would not take him, either. They just shrugged: he is too old, and we can't do anything, especially if you don't bring your own insulin.

Such traumatic experiences, however, did not mean that people would give up and not seek for further help. Instead, a variety of strategies were employed. Active pursuit for help in this group may be associated with its upward social mobility (as compared to previous generations). Nina Rusinova and Julie Brown indicate high awareness about one's individual responsibility for health in first-generation intelligentsia, suggesting that with an increase in education and occupational status, health comes to be regarded as yet another marker of one's achievements (Rusinova and Brown 2003). Often unable to find help by approaching institutional gatekeepers in the state healthcare sector, people developed a variety of compensatory strategies, such as reliance on the commercial sector, informal exchange of services or self-healing.

A few research participants mention seeking help from commercial medicine, whereby formal and informal fees for services were meant to substitute for a lack of social capital. For example, when Mikhail's condition had seriously worsened, and he developed a so-called diabetic foot, the family sold a country house with a plot, and paid for his treatment in a private osteopathic clinic. They were attracted by the 'latest German

technology' installed there. By that time he was almost unable to walk, and they were ready to pay anything to get him back on his feet. The treatment, however, was not successful. Expensive physiotherapy, combined with homeopathic methods, could not alleviate symptoms caused by high levels of blood sugar, not compensated by systematic insulin therapy. Eventually, to save Mikhail's life the family applied for a travel permit to Germany.

Since Mikhail had been employed in a grocery supply network, the family had no shortage of products necessary for his diet. Although the Ukraine has a strong agrarian sector, it used to export most of its farm goods to other USSR republics, and often experienced shortages of vegetables and cereals, necessary for balanced nutrition. Mikhail was able to arrange the supply with his former work colleagues.

Once help could be obtained, often it would be only half-satisfactory. Julia tells of her surgery:

The woman who did my surgery, she was a good doctor. She was a former army field surgeon. So, she cared little about beauty, and stitched me in such a way, that I cannot wear bikinis any longer.

Others still searched for some connections in order to access necessary resources. According to Rusinova and Brown, the connections skilled workers and first-generation intelligentsia could rely on would be of a lower rank (nurses, alternative healers, ancillary medical personnel), however, often they were quite effective (Rusinova and Brown 2003). My field material suggests similar patterns. For example, Ekaterina, who has a serious chronic condition (MS) reports on her positive experience getting treatment from nurses she knew personally in a large Ukrainian city where she said the staff

were doing a much better job than here. They were performing plasmapheresis on me, which is a major treatment method for my condition. There it was a matter of fact. I could come anytime and say 'Girls, I am feeling terrible!', and they would do all they could. Here plasma transfusion is only done for private patients. I was shocked! Certainly, medical help was better in the Ukraine.

Ekaterina comes from the same city in the Ukraine as Mikhail and Larissa and she was seeking help throughout the same period of time, perhaps even in the same hospital. Her positive experience, however, was determined by good personal relationships with nurses, medical professionals of her own rank (Ekaterina is a medical technician).

However, in spite of her positive experience with medical help, she had felt an overriding disempowerment in every other sphere of her life, often feeling unable to control her illness. Even relative health, as indicated by an ability to perform everyday tasks, was beyond reach for her when in the Ukraine, although at the time of our interview she was able-bodied and running after her grandchildren:

In the Ukraine I was told I would not live long. I spent months in the hospitals, and the doctors were telling me my days were numbered. I could hardly walk. I was a shadow. Officially, I was given the worst category of handicap. I think, had we stayed there, I would have died already. Of course, as I said, the medical personnel were very attentive and willing to help, more than here. But the air we breathed! Chernobyl was just a few dozen kilometres away, and I am sure my illness was caused by it. And there was nothing to eat, every day I woke up and did not know how I was to feed my children. Life was too hard there, it was impossible to go on like that.

One of the resources for this category of research participants was workplace medical facilities often attached to big industries. In accordance with the principle of 'proletarian dictatorship' some of those facilities were better supplied than the ones in the territorial network, however, with the reforms of the 1990s many of them have collapsed together with the plants and factories of which they were a part. Better satisfaction with workplace facilities also resulted from a feeling of having a personal relationship with their staff; having being employed in the same factory for many years, workers often were able to build some informal relationships with doctors, even if they were not of equal status.

Emma says:

The physician we had at that truck depot station, he was great! I could always come to him, and ask anything. Like, I had a pain in my back, and he would send me to do physiotherapy. Try to get a referral for physiotherapy here, that's too expensive! OK, he was rude sometimes, he could scream at you and tell you off for not taking care of yourself enough, but that was a sign of his care! He controlled you! He wanted to help you!

The feeling of 'being' controlled, which Emma contrasts with the 'lack of care' shown by German doctors is the core of a therapeutic effect for her. It is necessary to comment on the meaning of the verb 'kontrolirovat' and the noun 'kontrol' in Russian and its translation into English as 'to control' and 'control' respectively. A Russian-English

dictionary suggests ,to monitor' and ,monitoring' as an alternative options, however, ,monitor' is not an accurate translation of meaning attached to the Russian ,kontrolirovat'. People talking of ,control' in the ex-USSR meant that doctors were able and willing to determine the behavior of patients and supervise the running of treatment process. Medical professionals would maintain influence or authority over the patients. According to the Concise Oxford Dictionary of Current English (1990), all these meanings pertain to the verb ,to control', rather than ,to monitor' (which rather means ,regular surveillance' and does not imply hierarchy of roles in interaction). When talking about ,kontrol', interview participants often refer to hierarchical relationships and shift of responsibility for the treatment process to the doctors. Hence, ,control' seems like a more adequate translation. Statements about control will be discussed in more detail in Chapter 7 and 8.

In their position as first-generation intelligentsia, urban Russian German families (and the one Jewish family) can be categorised as *co-figurative*: having left their villages and moved into the cities, these persons needed to learn *from their peers*. The three-generation household is not a norm any longer: instead, parents live with their children till they grow old enough. Extended families cease being the main source of help, as in the case of the rural Russian Germans, instead, those fragments of institutional help which are accessible by single-generation networks are of great importance.

Thus, being 'controlled' and 'cared for' by medical professionals acquired a great meaning to this group of research participants: pro-actively, and sometimes even aggressively fighting for better health, they put all their hopes in persons who were treating them, having no other resources to count on. Their disappointment with the German healthcare system should be the strongest, as I will demonstrate in Chapter 7.

4.3 The Privileged: Self-Funded and institutionally-funded Jews

The group of the Privileged is composed of self-funded migrants and the Jewish quota migrants. Being recruited from the stratum of established urban intelligentsia, these persons had access to the greatest scope of resources they thought necessary for their well-being, and therefore, had the greatest feeling of control over their health. As I will argue further, many of them associate this feeling of control with *kul'turnost* or 'being cultured', and retrospectively create identity boundaries between themselves and the others, who were supposedly less refined. Moreover, control over the 'Soviet' reality is interpreted by some as a kind of dissident behaviour and a type of westernization, as I will discuss later in this section and in Chapter 5.

The urban second-generation intelligentsia was vastly privileged in its ability to get access to medical help, which resulted from their ability to mobilize inter-generational social networks and by-pass institutional gatekeepers, as Rusinova and Brown suggest in a series of publications (Brown and Rusinova 1997; Brown, Rusinova 2002; Rusinova, Brown 2003). The success of help-seeking resulted from the network composition. Unlike the networks of the fragmentarily empowered, who have achieved upward social mobility in one generation, the networks of the privileged included highly qualified medical professionals of the parent generation.

Thus their interaction with medical professionals was mostly enabled by the personalization of relations. Michele Rivkin-Fish explains this concept as follows :

Personalizing strategies stem from the Russian cultural practice of recognizing certain persons as 'our people', those who embody the potential trust, mutual understanding and reciprocity ('svoi liudi'). This is an inherently moral concept that is implicitly opposed to bureaucratic sources of contact, power and authoritative knowledge. [...] An implication of this is that personalizing strategies tend to represent unofficial kinds of practices, since they evade institutional procedures, legal rules and officially recognized forms of authority. (Rivkin-Fish 2005:10)

Personalizing often includes 'unofficial' access to treatment and resources it involves (human and material), compensated for by informal exchange of goods and services. This strategy is known in the Russian language as '*blat*', a practice widely used and ethically strongly distinguished from bribery or corruption (considering that in the atmosphere of general distrust to 'public' setting, surpassing institutional gateways is often

regarded as desired and moral). Several studies based on scrupulous fieldwork and excellent insider knowledge of the Soviet and post-Soviet societies have been dedicated to this pervasive phenomenon (Ledeneva 1998, Clarke 2002). Ability *lechitsya po blatu* (to receive healthcare by personal acquaintance) had been a privilege of the educated classes in Soviet society, as Rusinova and Brown (2003) suggest, given that the intelligentsia possessed the greatest amount of social capital, accumulating it through education and intergenerational transfers.

Several important patterns of help-seeking have been observed in this group, and most of them are fully consistent with evidence collected by Panova, Rusinova and Brown on the behaviour patterns of the urban intelligentsia (Rusinova and Brown 2003, Panova and Rusinova 2005).

First, self-funded migrants demonstrated a low degree of reliance on primary care facilities. Interactions with district polyclinics were reduced to a minimum. They were mostly contacted for utilitarian purposes, such as the issue of sick leave or the simplest tests. Consultations and interventions were, in contrast, organized by private means and often involved specialists of higher rank.

Sonja reports on a typical help-seeking episode during her childhood in Moscow:

If I just needed a sick leave for school then my parents called on a local GP who would just issue it. But if anything serious was necessary, then the phone calls would start, looking for acquaintances in this or that institute or hospital. My parents had a very large circle of friends, and if they needed a surgeon, they would find him through their friends. For example, once I woke up in the morning with a strong pain in my stomach, and I thought I had appendicitis. First, my parents called on a GP, but she could not say anything definite. So, we realised that to get anywhere we need to start making phone calls, so that a proper surgeon could take a look. And just a few hours later we were told where to go, who to ask for, and how to explain whose friends we were. And we did not even have to pay anything, I think. Those were different times, you would rather be expected to give a bottle of cognac, French perfume or may be silk stockings, I don't know. But that was it. Or, may be even, a box of chocolates, a jar of instant coffee or a bloc of cigarettes, that's what people wanted back then! My parents themselves did not know many doctors, just a few, but that was enough. They would just call them, and they would find a former classmate or a colleague. It was just a snowball in the end. Besides, my father was rather famous, people recognized him in the streets. So, if someone got a phone call and was told that a daughter of Mr NN will come to you for a consultation, it was easy.

Natasha tells a similar story:

I had to be registered with the local maternity clinic, you know, for bureaucratic reasons, I had to go there for regular check ups, just to tick it off. But birthing was, of course, organized through acquaintances [rozhala ja, konechno, po blatu]. I don't even remember any more whether we paid for it or not... Most important, the doctor was an acquaintance. And when he [her son] was born, naturally, we immediately found a paediatrician through some friends, and we mostly consulted him. We only went to the local paediatric polyclinic for prescriptions and sick leaves.

Boris reports his childhood memories of seeking help in Leningrad in the 1970s. Considering his father used to be a high-ranking dental surgeon, the family had an especially wide circle of networks in the healthcare system:

When I was sick, we always consulted some professors, some big shots [laughs]. No matter what the problem was. Never went to a polyclinic or anything.

The reason Boris finds the strategy his parents used for seeking help somewhat funny is the discrepancy between the banality of illnesses he would have as a child and the qualifications of the doctors treating them. Boris's family has continuously relied on this strategy having migrated to Germany, with his father, having established another surgery, yet again making contacts in the local healthcare system.

Second, in the case of hospitalization most of the interview participants were able to plan ahead and arrange being treated by an acquaintance practising in the necessary field. In case hospitalization was urgent, such an acquaintance would be found later in order to influence the treatment. In the context of constantly under-funded and under-staffed (post) Soviet healthcare, with hospitals becoming increasingly stripped of even the simplest equipment, the ability to plan hospitalization must be regarded as a very serious empowerment, as Rusinova and Brown (2003) suggest. It took a good deal of informal connections to find out which particular hospital possessed certain medication, equipment or qualified staff at the moment when help was necessary. Spontaneous hospitalization on the 'territorial' principle ('official' gateway) could, indeed, be a fatal event – or, on the contrary, an enormous stroke of luck. Therefore, great effort was invested into securing a treatment with a particular hospital.

Tamara says:

That hospital was horrible, it was falling to pieces. Very old beds, one toilet for a hundred people, I don't know. But the doctors were excellent! It is a very famous place in Moscow, everyone knows they have the best professionals. And because we knew it, I was treated there, by an acquaintance, of course.

Paul tells of his experience in the Soviet Ukraine:

In the Soviet Union I have never had any problems of the kind. You see, there I did not have to worry about anything when it came to getting medical help. That was determined by choice of profession (Paul had worked for the local Party Administration – P.A.). Anything could be easily arranged. And even before I started working there, I always had *blat* through my brother, who is a doctor. So, all doctors were *svoi*, nothing to worry about.

Third, interview participants who relied extensively on informal strategies either explicitly stated that they did not have to pay for their treatment (like Sonja and, partially, Natasha), or never mentioned informal payments, unlike persons in other groups. Instead, they were able to compensate in deficit goods they could obtain through other segments of their networks, or in services.

Blat arrangements can not be predictable by their nature, as Ledeneva suggests in her extensive work on this phenomenon: the informal exchange always leaves a room for interpretation, which in a medical setting may mean unforeseeable changes in staffing or treatment plan, influenced by interference of the institutional regulation (Ledeneva 1998). She suggests that while a lack of institutional transparency and staff shortages have produced *blat* in the first place, they have also made this strategy unreliable. However, as examples of less empowered groups of research participants demonstrate, a lack of connections meant a greater reduction of staffing predictability.

The active pursuit of different help options observed among intelligentsia also includes consultations with non-biomedical healers, especially those who legitimize their activities through reference to the scientific establishment: bio-energetic healers and practitioners of oriental traditions, as research by Lindquist (2002, 2006) suggests. For example, Misha mentions his parents' interest in yoga; Sonja talks about seeking help from Chinese medicine and homeopathy. In pre-perestroika years access to such healers was, in fact, restricted to a very narrow group of people, even within the intelligentsia, since their activities were semi-legal, and often performed under the control of 'closed'

experimental research institutes. After the ban on alternative medical practice had been lifted, consultations with healers became more ubiquitous. Lindquist observed (Lindquist 2001) that the intelligentsia was mostly reliant on the help of institutionally organized healers and paid for their services, both formally and informally.

The intelligentsia were altogether able to negotiate with medical professionals on the basis of personal trust, and developed an ability to negotiate and choose in an otherwise highly restricted total institution. Access to other resources gave these migrants a feeling of control over their life, however, some aspects of it remained out of reach, such as environmental pollution. Hence, whereas being able to make some choices about their health, people would also feel pressured to take some negative aspects 'as they are', because 'that's how life is'. This experience will further determine their perception of the liberalised, choice-based German healthcare system, as I will discuss in Chapter 7. Whereas the institutionally-funded Jewish migrants feel dissatisfied with German healthcare professionals, being unable to privatise relationship with them, self-funded migrants continue to access medical care by means of private networks and feel empowered by ability to make choice.

The privileged position of these persons is a result of continuous social mobility in several generations which occurred in their families. In a previous Chapter, I have already argued that self-funded migrants mostly belong to the Jewish ethnic minority, and, when not, can be compared to it in socio-economic status.

Throughout the 20th century Soviet Jews have undergone a significant shift in socio-economic status and cultural identity. Before the Revolution Marc Chagall was painting the everyday life of Jewish *shtetl* (settlements); by the end of the 1930s he would not have recognized these places any longer: the majority of the Jewish population lived in cities, employed in industrial occupations and lived a secular life (Schwarz 1951). The final end to *shtetl* traditions and religious life was brought about by the Holocaust, which exterminated a great proportion of the Jewish population in the Soviet West, just as in Europe. The life of mid-20th century Soviet Jews revolved around big industrial and cultural urban centres in the Soviet West, including Moscow and Leningrad. As a result, the post-war Jewish generations had very little or almost no connection to Judaism and the Ashkenazi traditions and religion, which were rooted in *shtetl* life. As a result of urbanization, secularization (mostly, forced), and education in several generations, urban Jewish families have become nuclear, and their structure can be categorized, after Mead, as pre-figurative, that is, families where the older ones learn from the younger. Generation and gender roles, thus, are more flexible in comparison to Russian German families.

Misha, who is 50, strikes a strong contrast to 48 year old Petr quoted in the first section of this Chapter:

Well, I am not forever young, but my plans and my beliefs have not really changed since when I was twenty five. Like, I wanted to change my professional occupation then, and I start thinking about it now. I live alone now, but if I had a family that would also be OK. But I have never really strived to have a family, not even when I was young. It just happened to me back then that I got married and had a child. I am an egoist, I have mostly lived for myself, always. I mean, not for myself, but in line with what I personally wanted and thought important for myself. When I was thirty I got married, but it was a coincidence, and if it had happened to me now, that would also have been fine: maybe I would have had more children. I don't know. It is good the way it is now, but it could also be good in any different way. I am open for options!
[Laughs]

This does not mean that Jewish migrants do not value strong family ties, since they discuss the importance of mutual support in the family. However, they conceptualise good family as a family where each member is capable of achieving her individual goal. Julia and Joseph also do not discuss their daughters' willingness to go about everyday chores. Instead, they highlight their high academic and employment achievements. Bella, when talking of her son, also says:

He is a very good son. He has started his own business here, from nothing, from point zero, but he got there! Now he has a house and he lives a good life. But he has two children and a mortgage, and I do not want to be a burden for him.

Tamara expresses a similar feeling about her son, a well-off entrepreneur:

Our Ilya, he is the best person I know! And he is so hard-working, he has achieved everything himself. He is very clever. If anything happens to us, I know he will help us. We try not to disturb him, but he always calls himself and asks how we are.

As discussed in the literature review, the concept at the heart of intelligentsia identity is *kul'turnost* or being cultured. Health is also conceptualised in terms of *kul'turnost*, which has two major functions: pro-active pursuit of knowledge and resources for its implementation and the segregation of 'others' into categories of *nekul'turnie* or 'uncultured', which is also expressed in terms of health. First, as applied to health,

kul'turnost implies the active pursuit of information and the desire to maintain a lifestyle seen as 'healthy'. Conceptualised as a result of a person's overall erudition and education, health comes to mean into achieved status and another marker of upward social mobility. Educational and cultural refinement also suggests ability and desire to make informed and rational choices.

Paul suggests:

In the final effect, how one is taking care of him or herself is a result of education, of their general *kul'turnost*. They should understand themselves what they need to do, what is good and what is bad for them. An educated person should have some idea about smoking, nutrition, etc.

Misha's opinion is similar:

It is all a matter of education. A cultured (*kulturnij*) person knows what he should eat, he will not get drunk all the time, will not smoke. One should have at least some understanding of how the human body is functioning, consult literature and think with their own head.

Irina, a Russian German young woman ambitiously trying to become *intelligentsia* by receiving a Masters degree, also says:

Health is a result of one's *kul'turnost*, of their education. It is just how you take the responsibility for yourself.

Second, it is the exclusive power of *kul'turnost* which plays a great role in how identity boundaries are created and maintained. Identifying themselves with *kul'turnie ludi* (people of culture), interview participants would cast themselves as 'healthy' against 'unhealthy' others. For example, Tamara says:

Well, I don't know what they told you in Marzahn, it might all be very interesting, I don't know, but we are different people here. You must understand, Charlottenburg is where *kul'turnie ludi* live.

In Chapter 5 will demonstrate that for some formerly privileged informants,

kul'turnost means the ability to 'shrug off the Soviet past', whereby bad health is attributed to 'socialist' habits and is explained by 'uncivilized', 'irresponsible' behaviours, which are cast against the 'cultured' West and its promise of better health and longer life. Being cultured, however, is not limited to being 'anti-Soviet', given that better educated Russian German migrants from rural areas in 'fragmentally empowered' and 'disempowered' groups also use this concept to explain good health and yet attribute different meanings to it. To them, being cultured means to observe tradition and to behave in accordance with a Russian German self-identification of a hard-working folk respectful of laws and rules.

Even the most privileged people attribute a great number of 'unhealthy' behaviours to the structural limitations of the Soviet past (and the Russian present) and the pressure to 'take life as it is'. For example, Natasha mentions the virtual absence of any leisure facilities in Moscow:

OK, we were rich, we had a dacha, and a car, and we could afford way more than other young people. But so what? There was no place to go! There was one pizzeria in Moscow, that is it! No normal place to go dancing! So, the only way to spend time in the USSR was to drink and smoke in the kitchens.

Research participants from Kazakhstan and Ukraine talk of environmental pollution and food shortages. Those structural limitations, however, are interpreted as hurdles one needs to overcome by means of his or her own agency. Shortages of information or material resources are irritating, but not unbeatable; the most empowered people stress that it is an individual responsibility of each person to overcome shortages. For example, they suggest that living a 'healthy' life under the limited Soviet conditions was possible:

Sonja:

We also lived in the Soviet Union, I understand, that is how life was there. But in our family we have never ever cooked all these kulebjaki or, God forbid, macaroni po-flotski. My mother always made sure we ate vegetables, and they were easy to get, really. Yes, it was mostly seasonal, and in autumn we ate aubergines and mushrooms, and in summer young potatoes, and in winter we would buy deep-frozen vegetables, but it was a rule: no fat, no heavy meals, no sweets. (...) We always took care of all necessary hygiene supplies, there has never been a shortage of anything in our house. I had a friend, her parents were artists or something, I mean, intelligentsia, but they were so bohemian they would not care. There was a shortage of medical cotton in the USSR, and whenever it suddenly appeared, my family knew they needed to buy a big supply in advance. And in this friend's family women would use some old cloths

for periods, you know, things like that. I mean, there is always a way to make a choice and also to live in comfort, one just has to take care of it, to think of it.

Misha:

Of course, in the USSR books about alternative healing or nutrition were hard to get. But the intelligentsia had their ways. My former mother-in-law had a whole library, books would be copied, photographed, I don't know what! If you want to learn something, you will, it is a matter of desire.

Some aspects, however, remained out of reach even for the most empowered: they suggest that political instability and environmental pollution are out of the individual sphere of control. Paul says:

By the end of the 1980s it had become clear, it was time to get out of there [bylo pora valit]. Ethnic conflicts started escalating, it was really smelling of a civil war. Add Chernobyl to that, and you have a picture of full disaster. You cannot hide from radiation, you know!

In the Chapter 5 I will demonstrate how different understandings of *kul'turnost* as individual responsibility for health affect migrants' help-seeking strategies. I will discuss how westernization and adherence to tradition are relied upon in different contexts by different persons.

Summary

This Chapter has demonstrated that different contexts of socialisation have led to the formation of very different health beliefs across the migrant Russian population studied. Regional inequalities, levels of education and types of family are likely to have served as the strongest predictors of people's understanding of health and of the ways they sought help in their sending countries.

In this Chapter I distinguish three groups of persons with respect to their backgrounds and health beliefs: the ex-disadvantaged (rural Russian Germans with all degrees of educational attainment), the ex-fragmentarily empowered (first-generation urban intelligentsia and skilled workers, mostly Russian German) and the ex-privileged (established urban intelligentsia, mostly Jewish). The health beliefs of these different groups oscillate between the concepts of *kul'turnost* (культу́рность - being cultured') and 'takaja zhisn' (,taking life as it is' or ,that is how life is').

Kul'turnost makes up the core of identity of persons who have previously belonged to the categories of 'privileged' or 'fragmentarily empowered' in their sending country, as well as in accounts of a formerly 'disadvantaged' family with higher education from rural Kazakhstan. In their accounts of a 'cultured' approach to health, *kul'turnost* has two major functions: the pro-active pursuit of knowledge and resources for implementation of this knowledge, on the one hand, and segregation of 'others' into categories of 'uncultured', on the other. Pro-active, individualistic health beliefs expressed by the concept of *kul'turnost* are related to a sophistication of help-seeking practices which had been employed by all privileged and by some fragmentarily empowered persons in their sending countries. The ex-privileged urban intelligentsia was able to act upon their beliefs by mobilising their informal networks, taking part in a complex system of informal exchange necessary to maintain balanced nutrition, gather information about health or reach medical professionals of the highest rank. Their high evaluation of health as an individual achievement was supported by their socio-economic position and by their family structures: mostly composed of nuclear families, urban intelligentsia relied on powerful 'weak' ties. To refer to Mead's conceptual apparatus, their families tend to have *pre-figurative* structures, with the oldest generations expected to learn from the youngest. The concept of *kul'turnost*, which refers to the ability of an individual as an autonomous agent to affect his health, is intricately related to the notion of *takaja zhisn* which embraces migrants' understanding of structural empowerments and constraints which determine their lives. This notion addresses one's self-identification with a collective

tradition of behaviour in the extended family: 'this is how life is, how we all live it'. As a health belief, it refers to circumstances which seem to be objectively affecting one's health. Understanding of health in these terms is particularly expressed in the formerly disadvantaged persons, who attribute their health to external factors: work, genetic factors and cultural tradition 'imposed' on them through generation and gender roles of their extended families. Post-figurative family, with its orientation towards past experience is an important source of such health beliefs.

Migration to a different country has, however, made the socio-economic context of stratification irrelevant, as I will demonstrate in the next Chapter. The majority of migrants, in spite of strong initial differences in educational attainment and qualifications, have experienced equally pronounced downward social mobility. In the case of institutionally-funded migrants, the German labour market has artificially 'levelled out' the formerly privileged and the formerly disempowered, by making them all into long-term unemployed welfare dependents.

However, differences in identity and family structures discussed in this Chapter have become accentuated through migrants' response to external categorizations imposed on them by the receiving society. The pressure to re-invent oneself under new conditions and reflect on one's identity causes shifts in migrants' health beliefs.

Chapter 5. Migration, Socio-Economic Mobility and Transformation of Identities. Effect on Health Beliefs and Help-Seeking Behaviours

This Chapter will look at how migrants' identities and beliefs about health change under new conditions of socio-economic stratification they face in the receiving society.

First, I will focus on different patterns of socio-economic mobility as experienced by persons who have taken part in different types of migration. I will demonstrate that socio-economic stratification of the sending country does not translate directly into SES differences in the receiving country. This section of the Chapter will look at the labour market as a main medium of integration.

Second, I will look at transitions in migrants' identities, caused, on the one hand, by external categorisations imposed on them by the receiving society, and by changes in socio-economic status, on the other. In particular, I will focus on effects the labour market has on family structures, suggesting that different types of families and identities produced in them adapt to migration-related changes in different ways.

Discussing and analyzing different types of social mobility, as well as differences in achieved statuses, we must bear in mind not only the effects of migratory processes, but also differences between generations of migrant groups. Those who arrived in the 1970s, were not only exposed to the economic and political setting of a different historical period, but had much more time to become established. The length of stay in the country, hence, is a very important condition of socio-economic mobility and identity transformation.

5.1 Socio-economic mobility in the receiving country

In spite of pronounced differences in socio-economic backgrounds, a great proportion of institutionally-funded migrants faces very similar problems when arriving in Germany and trying to enter the local labour market. Initial socio-economic differences between the Jewish urban intelligentsia and the Russian German manual class and rural dwellers become levelled out by long-term unemployment or professional disqualification.

Being a part of the urban intelligentsia, Jewish quota migrants have, in general, relatively high qualifications, as noted in chapter 3. However, higher education certificates do not help *Kontingentflüchtlinge* to find employment, with a great proportion of them suffering from long-term unemployment. According to the results of a survey conducted by Schoeps, an overwhelming majority has qualifications in natural sciences and long-term work experience as engineers, doctors and managers, but their integration in these highly competitive elite sectors of the German economy is highly complicated (Schoeps date: 90). Only a minority of Jewish immigrants in his survey stated that having spent three years in Germany they were employed in the profession for which they'd been trained (Schoeps date: 90). Besides, the unemployment rates in this group of migrants may partially result from their age structure: at the time of migration the leading age cohort was constituted by 30-40 year olds, closely followed by those between 40 and 50. Schoeps argues that this might have had a negative effect on language proficiency and flexibility in professional re-training (Schoeps: 92). In my research these observations hold true: none of the first-generation Jewish quota migrants had a paid job provided by an employer outside of the migrant community. Joseph and Eugene were long-term unemployed. Their wives, Julia and Inna, did a bit better; Julia has a permanent administrative job in the Jewish Community House, Inna is self-employed and runs a small second-hand shop.

The unemployment rates in highly qualified first-generation of urban Jews are comparable to those of semi-qualified Russian Germans coming from smaller towns or villages. According to Dietz, in the mid 1990s, when the majority of *Aussiedler* arrived, most of the people found their first employment within one or two years of arrival, however, though often these were temporary jobs with no permanent prospects. It is hard to provide reliable statistical evidence of long-term unemployment for Russian Germans because they are officially counted as German citizens. However, a few surveys can provide at least a general insight: according to the Institute of Labour Market Research, the mean level of unemployment among *Aussiedler* in Germany is about 30%, however, in Berlin it

reaches 52%, which is about three times the rate that pertains for native Germans in the same city (Damelang 2011). Similar results have been obtained by Dietz in her survey: a third of employed respondents said they had been jobless for at least twelve months before getting their latest job (Dietz 1995: 134). My own interview material also suggests that the majority of Marzahn-based Russian Germans of employable age are suffering from long-term unemployment or a precarious work situation and are reliant on social welfare.

On the one hand, these trends result from an equally poor command of the German language among Jewish quota migrants and *Aussiedler* alike. Long-term experience of ethnic discrimination in the USSR and Russia forced many Russian Germans to give up speaking German, so post-war generations of children would not be taught German at home. Therefore, whereas older Russian Germans often speak the language relatively well, persons of employable age have much poorer language skills. A survey study, which had been conducted in 1995/96 with young ethnic German immigrants who had come from the former Soviet Union to Germany at the peak of migration, that is, between 1990 and 1994, shows the diminishing language competence. Only a third of the young respondents had a good or very good command of the German language when questioned in 1995/96. More than a half of the young *Aussiedler* reported a mediocre knowledge of the German language, whereas a minority knew German badly or very badly (Dietz and Roll 1998: 64). Similar results have been obtained in surveys of Jewish immigrants (Schoepps 1996, Doornik 1997).

On the other hand, the qualifications and work experience of all migrants, regardless of their quality, are equally irrelevant to German employers: the overwhelming majority of migrants has difficulty gaining employment in the sector that they were trained for. This results from several reasons.

First and foremost, admitted into the country by formal channels, institutionally assisted migrants continue to rely on institutional support when entering the labour market and apply to statutory employment bureaus (so-called Job Centres) for recognition of their educational and professional experience. Paying little attention to migrants' 'soft skills', German officials refuse to recognize their diplomas and experience because of the differences in education and professional training systems. As a result, even most educated individuals often have to face downgrading and disqualification (Konietzka 2001). As for the Russian Germans, as discussed above, a high proportion of them was involved in agricultural labour and had relevant qualifications. Those who had worked in *kolkhoz* farms with little equipment or access to modern agricultural technologies, have no

skills necessary to compete in this market in Germany. Jewish migrants, trained in natural sciences or managerial jobs also have difficulties finding appropriate positions, given the highly competitive labour market sector they are trying to enter (Shoeps 1996: 90). The lack of official acknowledgment of qualifications is seen by many institutionally-funded interviewees of employable age as their most significant problem (e.g., Ludmila, Petr, Marina, Joseph, Julia, Galina, Sergey).

Second, structural changes in the German labour market have also led to a reduction of employment opportunities in unskilled manual sectors, thus exacerbating unemployment in persons with lower levels of education or those willing to accept unskilled jobs. Berlin is particularly affected by those changes (Häussermann, Kapphan 2005). As a result of re-unification Berlin has suffered from an escalation of unemployment, which has been determined by long-standing historical processes. Despite its immense industrial development in the early 20th century, during the post-war decades industries in both parts of the city were mostly shut down. In both East and West Berlin urban economies survived from statutory solidarity investments, which flowed in lavishly, considering that each part of the city was supposed to represent the success of the political and economic order it embodied. With the end of the Cold War, subsidies stopped, and unemployment skyrocketed, especially in the East. For a short period of time low-skilled manual labour was in demand due to the numerous construction sites which emerged in Berlin in the 1990s, with former Wall death strips being turned into lively areas and with decaying Eastern neighbourhoods being reconstructed. This trend, however, had subsided by the end of the 1990s, leaving many low qualified migrants unemployed. In 2000 Berlin became the capital of unified Germany, which was supposed to bring thousands of new workplaces in the political sector and strongly affect the housing situation, with prices in better neighbourhoods expected to rise dramatically. Neither of which happened, however. Even nowadays Berlin has the highest unemployment rate among big German cities, with very few industries located in the city, and most jobs coming from the service sector and the media. Berlin has the highest proportion of welfare receivers in the country and a significant external debt, which, according to a famous phrase coined by Berlin's current Mayor Klaus Wowereit, contributes to the city's dubious reputation as 'poor, but sexy'.

Third, many persons who had acquired their professional skills within the framework of the Soviet labour market find it difficult to adjust their expectations and work morale to the demands of the capitalist economy. Most migrants (Jewish and Russian German alike), regardless of their qualification levels, used to work for the same employer for many

years, and their jobs were often guaranteed by the state. Interpersonal competition, independence in decision-making and continuous professional re-training necessary for integration in the capitalist labour market had never been fostered in the USSR, moreover, they were regarded negatively as anti-collectivist. Therefore, migrants not only lack these skills, they often regard competitive types of behaviour as immoral (Dietz 1995).

Unlike in their home countries, institutionally-funded migrants cannot compensate for difficulties in finding employment by reliance on informal contacts: their networks are mostly composed of other persons in their own cohort and, thus, facing the same difficulties, being admitted to Germany under the same conditions and within the same period of time. To a great extent these networks emerge from the structure of the migratory process. On the one hand, many Russian Germans have migrated as an extended family, thus collectively experience the same problems (Dietz 1999). On the other hand, the emergence of cohort-specific networks was exacerbated by migrants' placement into transitional camps upon arrival, next-door with other families in similar circumstances (Doomernik 1997). Given that camp neighbours would often seek housing together, these networks remain intact for years after permanent settlement. Employment opportunities arising in such networks tend to be unskilled jobs, sometimes odd or semi-legal. For example, Irina's father, who used to be a mid-level semi-skilled manager in a construction business in Kazakhstan, had been offered a job as a truck driver 'with some Russians' (Irina does not know whether the business belongs to a Russian company or whether other migrants work for an ethnic entrepreneur based in Germany). He found this job by asking acquaintances from the re-settlement camp. Her mother worked as a bookkeeper in a grocery business in the sending country and now has a cleaning job in a company run by Polish migrants employing women from the former USSR. She works together with her former transition camp neighbours. Irina herself works for a Russian restaurant as a waitress, while completing her master's degree. Tanja is also doing cleaning for other people, but, unlike Irina's mother, she does it semi-legally, being formally long-term unemployed and reliant on social welfare. She says that if there are a lot of offers coming, she calls her cousin and other 'girls she knows from the camp' to take up the extra work.

Employment opportunities in ethnic entrepreneurship may also emerge through interaction with institutionalized network agents, such as migrant consultancy centres or the Jewish community. For example, several NGOs in Marzahn receive funding for language courses, self-help groups and cultural events, not only supporting persons who need help, but also offering jobs to other migrants. The Jewish Community is also an

employer of *Kontingentflüchtlinge*, offering them a variety of clerical jobs (Julia works there as a librarian, a profession she is trained for).

Jewish ethnic quota and Russian German migrants have similarly low SES in the Germany and face similar problems in entering the labour market, despite their different socio-economic and cultural backgrounds in the sending country.

In contrast, self-funded migrants seem to experience stronger upward social mobility. No sustainable data has been collected with respect to the employment situation and social mobility of the earliest, 1970s, migrants, however, my interview material suggests that their socio-economic mobility was quite successful, which eventually permitted them to sponsor further cohorts: Misha's and Boris's parents alike found jobs and remained employed until pensionable age; Sonja spoke of a family couple who helped her to enter a German university in the 1990s as 'successful people' employed in the local academia; Julia and Joseph got their flat from 'established' relatives who, by the time the new wave of immigrants has arrived, had made enough money to move out of council housing. Relatively easy integration into the labour market in the 1970s may be explained by the low number of migrants with comparable qualifications at the time (with Germany mostly accepting manual workers) and the overall positive climate of the post-war German economic miracle.

The self-funded migrants of the 1990s interviewed for this thesis are also well established in terms of employment and income, often relying on strategies of ethnic entrepreneurship. Paul runs a large grocery business with Ukraine, Sonja has a fashion retail company which also trades with Russia, Natasha is employed full-time with Boris as a dental technician. In their cases, the ability to receive sponsorship through cross-generational interaction with the older 'established' cohort played the decisive role. First, these persons were exceptionally empowered in their sending countries, coming from families of the highest rank and income in large urban centres. Second, upon arrival in the country they were quickly integrated into existing entrepreneurial networks, which permitted many of them to find a job without passing the institutional gatekeepers of the German labour market. Thus, formal recognition of professional qualifications and language skills, two major hurdles preventing institutionally-funded migrants from finding employment, did not pose a problem for these people who benefitted from private sponsorship. It is also likely that difficulties posed by exit and entrance barriers have produced a selective effect in terms of individual psychological traits of self-funded migrants, with persons willing to take risks and having strong entrepreneurial skills being over-represented in this group.

Thus, different patterns of social mobility experienced by migrants in Germany do not result directly from differences in their initial qualifications, but, instead, can be attributed to participation in a specific kind of migratory process and to networks related to them.

In spite of downward social mobility and long-term unemployment, many migrants, especially the formerly disadvantaged, believe that they have significantly improved their level of material well-being, which results from the overall difference between the state of public goods (such as the natural environment, housing, etc) in the sending and the receiving country. Chapter 6 will discuss migration as a 'transition to a world of plenty', and its perceived effect on health, in more detail.

Forced into unemployment, the welfare-dependent category of the population of the receiving country, each group of migrants develops its own response to the experience of downward social mobility and stigmatization associated with it (either perceived or directly experienced). Persons from different backgrounds draw on resources of their identities, re-inventing themselves under new conditions and re-defining who they are in the society they have entered.

5.2 Identities and Boundaries

Given the massive downward social mobility of persons from all backgrounds, their equal unemployment and dependency on social welfare, this common experience can be characterised by precariousness, as Bauman suggests:

The prime meaning of being “precarious” is, according to OED, to be “held by the favour and at the pleasure of another; hence, uncertain”. The uncertainty dubbed “precariousness” conveys preordained and predetermined asymmetry of power to act: they can, we can’t. And it’s by their grace that we go on living: yet the grace may be withdrawn at short notice or without notice, and it’s not in our power to prevent its withdrawal or even mitigate its threat. After all, we depend on that grace for our livelihood, whereas they would easily, and with much more comfort and much less worry, go on living had we disappeared from their view altogether... (Bauman 2011)

Indeed, many institutionally-funded persons feel that they had been admitted to Germany, and are able to enjoy a living standard better than in their sending countries, by pure *grace* of the receiving country. In that respect, *gratitude* makes up an important component of identity in many institutionally-funded persons. Unlike self-funded migrants, who conceptualise their admission into the country as ‘well deserved’, whether as a compensation for political prosecution, or as a result of individual effort, institutionally-funded migrants reflect on their admission as a ‘favor’, for which they are in debt.

In Tamara's words:

We have nothing to complain about! Germany is a wonderful country, we are very grateful for being here! The nursing care we receive, this alone is just so amazing, it would have never happened in Russia! And who are we for the Germans, strictly speaking? No one! Total strangers! And they still care for us.

Erwin and Kristine also express gratitude:

Every day we say, thank you, Germany, for taking us! Our lives here are very good, we have an apartment we like, we can buy any food we want, everything is very well thought of. One has to be grateful for this, it is not for free!

At the same time, persons in a precarious position, argues Bauman, deny the

commonality of fate:

They render calls to solidarity sound ludicrous. Precarians may envy or fear each other; sometimes they may pity, or even (though not too often) like one another. Few of them if any, however, would ever respect another creature 'like him' (or her). Indeed, why should s/he? Being "like" I am myself, those other people must be as unworthy of respect as I am and deserve as much contempt and derision as I do! (Bauman 2011)

Indeed, the next two sections of this Chapter will demonstrate that the transformation of identities through the migratory process is related to the maintenance of multiple identity boundaries, both external and internal to the different communities represented in this research. In literatures which regard identity as a process, it is implicit that identity change occurs only when interaction must be maintained, when disengagement is not a practical option (Jenkins 2008: 123). Institutionally-funded migration to Germany has led groups of persons who were almost completely disengaged from one other in their sending countries, into close contact. In that respect, external categorisations imposed on migrants by the receiving society are of great importance: persons who have hardly known of each others' existence in the sending country, and have identified themselves in different ways, suddenly become collectively drawn into the same category of 'Russians' by the receiving society, which does not distinguish between different groups of migrants from the USSR in the media, artistic and everyday discourses. The acknowledgment of differences exists only in the legal context of acceptance policies, and even there it is reduced to formal ethnic status, often irrelevant to the complexity of migrants' self-assigned identities. At the same time, Russianness as an external categorisation is usually related to perceived stigmatisation.

First, being categorised as Russian means jeopardising one's right of having been admitted into the country as a *Kontingentflüchtlinge* or *Aussiedler* and challenges one's right to maintain access to public goods meant for members of Jewish or Russian German ethnic minority groups. This can be illustrated by conflicts in the Jewish communities, which result from discrepancies in definitions of Jewishness in religious tradition and policy making. On the policy level, the degree of 'Jewishness' necessary to receive an entrance clearance has not been defined for ethical reasons: if being a quarter Jewish was enough to be sent to Auschwitz *back then*, should that not be enough to be issued permission to move to Germany *now*? Besides, the quota refugee policy does not distinguish between maternal and paternal ancestry, which contradicts the Jewish religious law, *Halakha*,

according to which only those born to a Jewish mother can be considered as Jews. These apparently contradictory definitions of ethnicity lead to perpetual confrontation between the Jewish communities and the newcomers: the communities established in Germany will not accept new arrivals as 'real' Jews and often suspect them of coming to the country with fake papers, only seeking access to material resources, and not being interested in Jewish cultural and social life (Becker 2001; Economist 2008). As for Russian Germans, most of their formal organisations make efforts to reconstruct their public identity from the history of Soviet discrimination, thus conforming to the victimised role of an *Aussiedler* and in order to symbolically justify their acceptance into the country.

Second, 'Russianness' as an external categorisation is usually related to negative meanings, which become attributed to all groups of migrants, regardless of ethnic status and migratory experience. Problems 'specific' to 'Russians', as discussed in the German press, academia and policy making, concern juvenile delinquency, unemployment and a high rate of crime. At the same time, those problems are discussed exclusively in relation to Russian Germans, that is, on the one hand, *Aussiedler* as referred to as 'Russians', and on the other, they are cast against the 'local' population as 'dangerous'. Jewish *Kontingentflüchtlinge* or self-funded persons hardly ever appear in the local media discourse as specific groups of migrants. The general categorisation produced by media confusion makes everyone into 'dangerous Russians'. Becker writes of identity transformation in Soviet Jews upon arrival in Germany (2001: 72):

They have become Russians, although Russian not only means poor ability to integrate and accept standards of leading culture, but is also steadily associated with mafia-like dangerous types of social organisation.

Thus, being identified as 'Russian', means being accused of non-compliance with the standards of *Leitkultur* (leading culture), which, according to the state of the German migration and integration debate at the time of the migrants' arrival, is a deadly sin (as discussed in the Introduction). 'Russianness' as an external categorisation undermines one's legitimacy as a migrant and reduces one's status. In a response to this external categorisation, identity boundaries emerge.

In public setting 'Russian' is used as an external, mostly negative categorisation. In private settings, however, people may identify themselves as Russian. A situation of an interview is a good example of such identity shifts. Whereas the interviews are likely to start with manifestation of identity other than Russian (people introducing themselves in

terms of their migrant status or identity), towards the end of the conversation they may talk of 'seeing other Russians' and talking of themselves as 'us, Russians'. The 'Russian' identity, however, is more likely to occur in contexts when migrants are casting their beliefs, habits and practices against those of the receiving society. In that case two general categories of 'Russian' and 'German' clash, whereby 'Russian', in fact, often refers to 'coming from the former USSR' or 'belonging to the former Soviet experience'. Such folk categorizations are, to a great extent, a result of Soviet ethnic policy which aimed to enforce Russian language and culture in all Soviet Republics. For example, Misha says:

People from the former USSR, Russians, whoever, they are not like Europeans. All our people were the same, they were like clones. In all republics you would have the same food served for New Year's Eve. Whether it was Lithuania or Kazakhstan, does not matter.

'Russian', however, can also have positive connotations. For example, Misha and Marina, persons with extremely different backgrounds, say the same phrase:

We, Russians, our children respect the elderly more.

'Russian' as a native categorisation can be both positive and negative, and is usually employed in contexts when common experience in the former USSR is being opposed to what is perceived as common experience in Germany. Yet, migrants' precarious position, characterised by direct dependency of resources on ethnic descent, causes constant unease, whereby people within one category tend to constantly estimate the authenticity of others' ancestry, thus, controlling the 'just' distribution of resources. In that respect, classification of 'us' and 'them' is based on qualities persons consider to be immanent to 'real' Jews or 'real' Russian Germans. Whereas the latter judge each other in terms of *kul'turnost*, the former draw on others' diligence and adherence to family roles.

In the next two sections of this Chapter I will discuss how identities in different categories of migrants transform throughout the migratory process, and how new health beliefs become adopted into them.

5.2.1 Transformation of kul'turnost: Westernizing individual behaviour

Throughout the process of migration, *kul'turnost* acquires the meaning of *westernisation*: that is, adopting behaviours and practices migrants believe to be immanent to the 'West'. Westernisation also pertains to the realm of health beliefs, whereby the 'healthy' West is often cast against the 'unhealthy' socialist world.

In fact, westernisation is an important component of Soviet Jewish identity. In that respect, migrants' rationalisation of the choice of Germany as a destination for migration provides important insights. In a few interviews with Charlottenburg Jews Germany is referred to as a country of 'high' culture, and, thus, a place most suitable for a member of the Soviet intelligentsia. Israel, in contrast, is cast against Germany as an 'exotic', 'oriental' country with lack of civilisation, and even the USA is referred to as a place with a lack of an artistic and intellectual tradition.

Inna says:

We just wanted to go to a normal European country, to the West. I would not even think of Israel. This middle-eastern mentality, it is too remote for us. Besides, the climate is unbearable. Germany is a country of great culture, a culture we all know from childhood. Think of German writers, composers, of this entire legacy... It is much closer to us, it is Europe! And the USA... It is a country of consumerism, it is not about culture, it is just money and chewing gum.

Tamara's opinion is similar:

Israel has a middle-eastern mentality. It is wild, uncivilized and raving religious. Germany, instead, is very close to us culturally. We all read Goethe, and listened to Mozart, we know this tradition and understand it. What is there for us to do in Israel?!

Julia's choice of Germany is based on practical, rather than spiritual considerations, however, it is still the degree of 'civilisation' that matters:

The two most important criteria for me are education and medical care. So, I gathered information about Germany, Israel and the USA, and I decided Germany was the best for us. In Israel, I have heard, you pay thousands of shekels for every visit to a doctor. And the education is quite poor. The US has

good universities, but, again, you know how many problems they have with healthcare. We had children and we needed to think about things like that! I have never regretted we chose Germany. We are very happy about everything here, both in terms of medical treatment and education. Our girls were able to go to the university, Lisa is making a PhD now, so, what else can we wish? I doubt we would get that far in Israel.

Westernisation is characterised by strong *anti-Soviet* beliefs. In this context, settling in Charlottenburg signifies, among other things, disapproval of all things socialist. For example, having arrived at the beginning of the 1990s, Sonja witnessed the re-making of the city, and, unlike early migrants, travelled freely between East and West. Throughout her student years she lived in different parts of Berlin, including former GDR areas. She makes a striking contrast between the two parts of the city in her accounts:

East Berlin, it was like a post-war zone. I first lived in Charlottenburg, but had to move briefly into Friedrichshain [an East neighbourhood with a strong reputation of 'alternative' and 'punk'], which was terrible! There were no normal shops, no supermarkets, just Vietnamese people selling all sorts of stuff in the streets. The pavements were broken, the streetlights not working. And most important, it is people! No one was smiling there, everyone looked just drab. It was just like back to the USSR, I was genuinely depressed there. Like, when the S-Bahn would pass Friedrichstrasse station, meaning we are entering the East, my mood would spoil immediately. I totally hated it, and could not wait to move out. There was no civilization there!

Sonja uses the concept of 'civilisation' to invoke the difference between East and West and the people living there. To her, civilisation is centred around Ku'damm, in the familiar setting of Charlottenburg:

The West, they had it all. It was clean, there were normal shops, people were smiling. It was civilized!

Westernisation of individual behaviour is also regarded by many *kul'turnie ludi* as a pathway to health. As we sit in a restaurant not far from Misha's workplace, my recorder on the table, he critically investigates a garlic baguette which arrives as a starter, and takes a piece after what seems to be a minute's restraint:

I usually do not eat stuff like that!

I ask him why, and he continues, passionately:

I watch out for what is healthy. One should not be like an animal, like all those uncivilized [dikia] Soviet people who have no idea about their health.

Having come across similar ideas in academic literature (as discussed earlier in this thesis), I am prepared for this opinion, and I ask him carefully why he thinks 'Soviet' people are like that, and he suggests:

Life itself was harder, of course. And beliefs and values were more primitive, more simple because of that. But mainly, people were cut off from some very important Truth, that western Truth we live with now. Altogether, it was a special kind of world which would give birth to a special kind of people.

The word Misha uses for 'truth' is a somewhat old-fashioned term, mostly employed in poetic or religious contexts: *istina* (истина). This word means 'enlightenment', 'insight', the *ultimate* truth (this is the reason I use capital letter in translation).

By using it, he suggests the importance of what he believes to be a 'western' lifestyle, and places it high above other ways of living. Besides, Misha categorises people who have been socialised in the USSR as altogether 'different' and imprinted by socialist ideology. Indeed, his strategy of 'othering' resembles that of some academic literatures.

Throughout the rest of the interview Misha characterises persons remaining in his motherland and 'other' migrants as 'Soviet' people and attributes to them all sorts of behaviours he considers unhealthy: unbalanced nutrition, alcoholism, smoking, abuse of antibiotics and violence. Misha believes it is their 'culture', or, rather, lack of it, which makes them into unhealthy people:

They get ill quicker, fall into pieces, eat trash. Our guys drink far too much alcohol which destroys them. And women do the same. Those are the kind of bad habits they have. They do not know how to eat well, they do not exercise as young people, then they start deteriorating and by fifty years old, in fact, they are ready to die.

Although Misha's accounts of his former countrymen are almost grotesque (in one passage he refers to them as 'walking digestive tracts'), other persons also make connections between 'Soviet' and 'unhealthy'. In many cases 'Soviet' and 'Russian' are

used as interchangeable concepts, which to a great extent mimics the public discourse and external categorizations imposed on migrants by the receiving society. The internal relationship between 'Soviet/Russian' and 'unhealthy' constitutes a part of general stigma attached to all things 'Russian' and 'Soviet' (as discussed above). Health, in contrast, is associated with the ability to behave as a 'Westerner' and to depart from the 'Soviet' past or from reliance on the infrastructure of services provided by the migrant community. Dissociating themselves from the sending country and shared experience of life under socialism, migrants cast them against 'German' as uncivilized, destructive or even dangerous. Hence, *kul'turnost* is often understood as the ability to westernize oneself, to change one's individual behaviour.

As the quotes above suggest, Misha speaks of his former countrymen with little compassion. Although he recognizes the external limitations they faced ('life itself was harder'), as a militant proponent of *kul'turnost*, he argues on several occasions that it is one's responsibility to circumvent the difficulties. Indeed, other persons from the previously privileged background claim that they were able to develop autonomy from the socialist reality already prior to migration and were behaving like 'westerners' in their sending countries. Misha speaks of his childhood:

My grandmother was from Germany, and she would make all these salads for us. The poor Soviet people around us, they were not getting it. Like, they would laugh, you guys eat hay, like cows. They had no concept of healthy nutrition, the way the people in the West ate.

Access to Western media or, actually, ability to travel also resulted in behavioural change for Sonja:

In the USSR no one knew about oral contraceptives. They were regarded as some dangerous, horrible hormonal medicines which are very bad for you. A doctor in a Moscow hospital told me once I should rather do one abortion after another, than take the pill! Nonsense! I learnt about the pill when I was still at school. You know, my parents managed to put me into this really elite school with extensive learning of German, and we had all sorts of exchange going on with FRG kids. And they used to bring 'Bravo' magazine with them, with advice on sexual health published in every issue. They had this figure, Dr Sommer, whoever he was. I read his article about the pill there, translated it and gave it to all my girl friends! Of course, in Russia no one would have prescribed them to me. So, as soon as I came to Germany, I went to a gynaecologist and asked for a prescription. Was no problem at all here.

At the same time, those who were less empowered in the sending countries also express satisfaction with their ability to be more 'responsible' upon migration. However, they speak of the limitations they experienced back 'home' as much stronger determinants of their health: 'taking life as it was' 'there' would not give them a chance to change their individual behaviour, they believe (see Chapter 4). However, they demonstrate eagerness to westernise themselves on arrival in Germany.

Referring to her husband's diabetes, Larissa reported:

Of course, back there we were completely uneducated about anything. No one would explain anything to us! And here the options are just much better, like, a course about diabetic nutrition, all these books, it is a totally different life. I am trying to find out as much as I can. If the Germans offer me such an opportunity, I will gratefully take it, they know better, one just has to follow their advice if one is in their country.

Marina, who comes from a Kazakh village and has a higher education, also sees migration as a chance to change her 'old' habits for the better, 'western' ones. Unlike working-class persons in the previously disadvantaged category, she is eagerly embracing the new ways of nutrition, for example:

What kind of vegetables did we know in Kazakhstan? Potatoes, carrots, cabbage, turnip, maybe once a year tomatoes. That was it! Of course, we knew nothing of balanced nutrition. And here, we go to a supermarket, and there is spinach, for example. God knows how to cook it, we have never seen it before! So, we try hard to be like Germans, we realize we should eat more salad, and we try to get used to all these new sorts of vegetables. And you know, the kind of soups they do here, for example. It is usually vegetable puree, like, pumpkin, carrot or spinach. And in Kazakhstan a soup is a heavy meat broth with a lot of potatoes in it. It is hard for our people to get used to that, but I know we should, it is good for us.

However, migrants argue, simply being admitted to Germany does not mean an automatic change in individual behaviour: it is one's personal achievement and merit to be a Westerner. Misha, an outspoken advocate of a 'healthy' lifestyle:

There are people here who moved, like, thirty years ago, but they still live like in the Soviet Union. They eat all this heavy food, you know, meat and borsch every day, and drink vodka, and nothing changes for them. They are like

dinosaurs.

Marzahn and persons settling there receive the strongest stigmatisation in the accounts of Charlottenburg-based migrants: their descent from social classes other than the intelligentsia and their residential preferences suggest that they are not *kul'turnie ludi*. The fact that they are, supposedly, uneducated and settle in the former GDR part of the city suggests further that they are not susceptible of any westernisation, and are, thus, not worth talking of. The greatest stigma attached to Mazahners is the lack of *kul'turnost*. In different contexts different people call them 'savages' (Lena), 'uncivilized' (Misha, Sonja), '*beskul'turnie*' or non-cultured (Tamara). In Misha's words:

They are all unemployed, all day long they just sit and drink, like back home. Do you know how mental illness is treated with them? The shrink just turns on the recording of country sounds, like, tractor noise and birds signing, and they lie on the couch, listening. They go nuts without a village!

Boris also complains of his Russian German dental patients who behave in an unhealthy 'Soviet' way:

They have no idea about dental hygiene, they just expect me to do everything for them. They cannot even brush their teeth properly, it is such a Soviet mentality!

Charlottenburg-based Jews would, perhaps, be surprised to find out that persons with higher education in Marzahn, willing to identify themselves with *kul'turnost*, also employ westernisation discourse when distinguishing themselves from the others. Galina speaks of differences in pregnancy conceptualisation 'here' and 'there':

I have a lot of friends among younger women, and when they get pregnant, I always tell them, hey, pregnancy is not an illness! Live a normal life, don't be such a Soviet person, it is normal to be pregnant for a women.

Marina talks of herself, learning the peculiarities of local cuisine, and the 'others' as unwilling to adopt the German nutrition patterns:

I have heard that some of our people who lie in the hospitals here don't eat anything. They cannot eat German food, they do not understand what it is. (P: How do they cope then?) Somebody brings them food from home, and they eat what they are used to, or they go to a hospital cafe if they can, and chose something else.

In fact, a similar perception of Marzahn as a 'socialist' place with respect to lack of health awareness, appears in interview accounts of the Maiers, the native German household maintaining a private house with a garden on the rim of the neighbourhood. Given that Stephan Maier comes from a dissident GDR family, which left for the West in the late 1980s, his critical assessment of post-socialist Marzahn is understandable. The couple complains about lack of 'healthy' shopping infrastructure, in particular, the absence of organic groceries, Stephan says:

People here have not departed from their socialist habits yet. It is very retarded here. They do not understand the benefits of bio, what responsible consumerism is. They neither care for themselves, nor for nature.

Marlene, his wife, expresses a similar opinion in an interview she gave me separately:

Even if you open a bio-shop in Marzahn, no one will come there, you will go bankrupt. People are ignorant, they have these socialist minds.

The Maiers also complained about the 'Soviet' approach of Marzahn-based doctors, and the virtual non-existence of alternative healing options in the neighbourhood. The Maiers and some Charlottenburg migrants, in fact, experience a similar situation: whereas they identify themselves strongly with what they believe to be Western values, including health beliefs on responsible and individualistic nutrition, they feel permanently confronted with the aggressive, uncivilized world of former socialism surrounding them. Whereas for the Maiers the animosity comes from Marzahn itself, for migrants who have the ambitions to turn into 'civilized Germans' it is the 'others'.

In spite of references to a common enemy, among *kul'turnie ludi* of Charlottenburg there is no solidarity and a narrative on mutual excommunication between them is highly important to understand the fine differences in the conceptualisation of *kul'turnost*. The internal identity boundaries expressed by Charlottenburg migrants also distinguish between those who possess more and less *kul'turnost* and those are more westernised

than the others. In that respect, the early self-funded migrants enjoy the status of an aristocracy in exile, identifying themselves with the practices of *real* anti-Soviet political dissent and intellectual revolt, and labelling the later wave as 'sausage emigration' (*kolbasnaya emigratsia*), that is, composed of people motivated by economic considerations only and attracted to Germany by the abundance of 'sausage' (*kolbasa*), a concept used in Russia not only to describe a particular meat product, but also as a derogatory word for all things material and mundane. The difference between groups of migrants discussed is a difference between political refugees and economic migrants, which is not a specific Soviet phenomenon, and has been observed in other societies as well (Gans 1994, Cortes 2004). *Kul'turnost*, however, is a specific term used in this migrant population to conceptualise the identity boundary.

Misha, when asked whether he is a member of the Jewish Community, says:

No, not any more. I used to be, when we arrived in the 1970s, and in the 1980s. Back then it was different, it was very small and very German, we were the exception there. And now it is just a Russian bogadelnja [a derogatory term meaning nursing home for the poor].

Bella complains of being stigmatised by an old acquaintance:

This Anna, you know, she was my classmate! And now, she is just a very arrogant person. She moved here in the 1970s, married very cleverly, you know, a Jewish doctor who opened a surgery here. She never had any material concerns. And then, she tells me, before you guys came here it was much better. She was asking me, why did you all have to come, could you not stay home a bit longer? Like, the kolbasa in Russia is just as good as here now, you just had to be patient. It was much better without all you guys, she said, you are just a bunch of Soviet people.

Indeed, the end of the German economic miracle coincided with the collapse of the Iron Curtain. The 1970-wave migrants, however, attribute the decline in the economy to increased migration and unification: they believe that socialism infiltrated their 'sacred' world, protected by the Berlin Wall. Paul arrived in Berlin a few months before the Wall collapsed and two countries merged into one nation. In spite of his only brief encounter with what used to be West Germany, he seems to be adamant about the benefits of the Iron Curtain for the capitalist economy and its healthcare:

I am telling you, it was much better here, before the wall came down. Doctors were much better paid. Like, I have these friends, they came in the 1970s and opened their surgeries back then, and they say it cannot be compared to what they earn now! Scraps! This is all because this unification thing was so bloody expensive. Loads of healthcare money had to be invested into raising the GDR standards to the ones here. The whole insurance business worked differently, anyways, so that doctors would earn a lot more from each patient, so they would care, they would treat you personally. And now it is all rationed, like under socialism, so that they need to have a real conveyor belt to make a profit. You know how much it costs to maintain a surgery? They need to lease everything first, and then it takes years to pay everything back. In older times it would go much quicker, because the insurance companies would also support them. And now it all shoots back to the patients. They have no time to talk to you, it all must be quick. The quality of healthcare dropped very much.

The later self-funded migrants who arrived after the collapse of the Iron Curtain cannot identify themselves with political dissent, however, they cast themselves against the institutionally-funded as persons who *have achieved everything themselves*. Instead, *Kontingentfluchtlinge* are regarded by self-funded migrants in all generations as person possessing characteristics, typical, in their opinion, of Soviet people: passivity and a parasitic approach to resources, *believing that everyone owes them*.

Passivity means lack of desire to change one's individual behaviour in accordance with the norms of the 'civilized West'. As I will demonstrate later, this discussion is particularly heated in the realm of nutrition.

Natasha says:

You will not see our people shopping in the organic shop. They do not get it. (...) They are across the road, queuing for frozen pizza and kolbasa [sausage] in a supermarket.

'Passive' institutionally-funded migrants are blamed for their 'parasitic' approach to the resources of the Jewish Community House. Self-funded migrants employed there in managerial positions complain of the 'neediness' of the latest cohort:

Karina, from the Social Work department of the Community Administration says:

These people are so needy, you cannot believe it. They just want to take, and take, and take. They think everybody owes them, that they are special. Such a Soviet mentality!

Tatjana's words are similar:

Some of our Jews got used to presents from the Community, you know, there were always some gimmicks for the New Year and the Jewish holidays. But now the funds are short, and they are pissed off. They think everyone owes them. You know, typically Soviet behaviour, like, expecting someone to do everything for you.

Stigmatisation also expresses itself in doctor-patient relationships, given that many Russian-speaking physicians in Berlin belong to the early self-funded cohort. Boris talks of his Jewish patients:

These new Jews, they are the worst. Russian Germans, OK. they are not too bad, just uncivilized. But they keep quiet. And Jews, they think they are some kind of special people. Indeed, the chosen folk! Like, they want me to give them some discounts or treat them for free, because I am Jewish too. But, doctor, you must, they say. I really hate it. I owe nothing to anyone, I remind them.

Westernising one's own individual behaviour is also endorsed by pre-figurative structures of former urban intelligentsia. This is especially true for the families of self-funded migrants, who, literally in Mead's words (Mead 1970: 56):

Came as pioneers to a new land, lacking all knowledge of what demands the new conditions of life would make upon them. (...) Among the first comers, the young adults had as models only their own tentative adaptations and inspirations. Their past, the culture that had shaped their understanding - their thoughts, their feelings and their conceptions of the world - was no sure guide to the present. And the elders among them, bound to the past, could provide no models for the future.

On the one hand, formerly better empowered, urban migrants conceptualise the difference between themselves and 'local' Germans in similar terms as rural Russian Germans do (as I will discuss further). Even Misha, who is a militant proponent of westernization in every possible aspect of life, says, reflecting on intergenerational

relationships in migrant and local families.

I think, old Germans live very well, I am happy for them. But they have their own life, they have had a different history, and their relationships with their children are not like ours. I think their lives are more egoistic. Russian-speakers, they treat older people better, more positively. Young Germans are harsher to their parents. I think they don't really respect them or they don't like them, I do not know, maybe this is because of the wars these people had started, or because of how they treated their children. I think, Germans do not have family values [net semeinosti], they are egoistic, and they get it back from their own children, so that when they get old they are very quickly sent into a nursing home. We have much a closer relationship to our parents. (...) I visit my parents very often, help them if they need to go somewhere far but, in fact, my father drives, so he is independent. And local Germans, they think my son is spoilt. Because according to their understanding, we do too much for him, like, he's got to make everything on his own. But I think, this close contact to my son, it will bring some fruits later. It is not like with them, that he has to get out of the house when he turns eighteen so that I could go travelling easily. For them, children are only secondary, they are spoilt by egoism.

Misha does not criticise the younger generation, instead, he attributes looseness of family ties to the 'egoism' of parents. Unlike Russian Germans, he does not place an expectation of 'duty' on children, rather stressing the role of parents as responsible for tight contacts.

He argues that this type of familial relationships results in *kul'turnost*:

We, Jews, we invest a whole lot in our children so that they grow up as kul'turnie ludi. Poor Jewish parents, we are not like some people in Marzahn, we run around like mad to put our kids in this club, or that club, to drive them to a swimming pool or whatever. And, hence, with us there is no unemployment. Everyone is educated and kul'turnie.

Recognizing this difference and being critical of some aspects of German upbringing, Jewish migrants in all cohorts endorse the idea of individual 'liberty' of the modern families and the 'independence' of the children, which results from pre-figurative structures of these families. New values adopted by children are not regarded as a threat to tradition: instead, tradition is perpetual learning from the younger ones. Misha also says:

I like modern young people very much. I have no problems with them. I rather feel I live in one world with them, not people of my age. Like, my son and myself, we listen to the same music, go to the concerts together. There is no conservatism, like 'that is for my Dad and that is for me'. No, I learn from younger people, they bring new things and civilization.

Bella, who age-wise could be Misha's mother, speaks of her grandchildren:

They are totally German already, not at all like us. But I like it! They are very independent, they fear nothing, they make their own choices. They go studying abroad and make it on their own.

Given the pre-figurative structures of their families, unemployed or retired migrants from the former privileged background feel less confronted by a clash with the rapid success of the younger generation and their own relative decline. They continuously compensate for losses in status by acquiring more *kul'turnost*. Lena, whose father was a well-established doctor in Leningrad prior to migration, says:

Of course, they were too old to start looking for jobs. That was obvious. So, that part of life was gone forever. But they go to the Opera, to the exhibitions, like they did before, they learned to use the Internet, so they live a good life, very much like in Petersburg. Their friends are kul'turnie ludi, perhaps, less educated, but still, ok.

Tamara's husband Grisha says:

I could not imagine I would never work again when we came here. For Russian standards, I could work, even at my age. Late fifties is nothing, with us everyone keeps working. I had colleagues who were seventy. But here no one wants you when you are old, and then you must retire. At first, I was desolate. But then, we started enjoying other things. Going to the Opera, concerts, things like that. When we are feeling not too unwell, we go on guided tours, Berlin has plenty to offer, it is a centre of world culture!

Altogether, in families of formerly privileged urban intelligentsia (mostly Jewish) westernisation does not seem to oppose tradition in a way that happens in Russian German families. Instead, westernisation becomes smoothly embedded into tradition as a continuation of *kul'turnost* pursuit and pre-figurative family structure.

5.2.2 Diligence and family ties: Preserving the tradition

Effects of unemployment or precarious forms of employment, resulting from the highly competitive labour market, as well as changes to family structures resulting from migration, are strongly conceptualised as possible causes of bad health in interviews with Russian German migrants in all groups: these new challenges go against the grain of their self-identification with the values of hard work and extended family (as discussed in Chapter 4).

The Russian German ideal of an extended family where everyone works and contributes to the common lot becomes challenged by migration. Not only does it happen because families are torn apart by quota settlement policies, spreading them across different federal lands. In fact, the geographical distance seems to be reflected upon by my interview participants only marginally; instead of complaining about it, they talk of visiting each other in all parts of Germany. It is the erosion of generation, gender and employment roles which is regarded as a threat to the common tradition.

First, given that children adopt the norms of the receiving culture quicker than their parents (mostly, by means of education), the post-figurative culture of such families is challenged. On the one hand, the middle-aged generation is proud of extremely hard-earned success of their children:

Ludmila, whose son has just completed military service, and whose daughter was studying in the university at the moment of the interview, says:

We are a good, normal family. We have two children, who are right now on a very serious crossroad, trying to find their way. They apply huge, enormous energy to achieve anything in life. I cannot understand how they make it, but all I do is support them. They try hard, they study. We are very proud of him.

Marina, who has two adult children, speaks of them very similar:

When we came here, they were already nineteen and twenty two. It was very hard for them. But now they are doing very well, they receive education, they try working, they are our great pride!

On the other hand, children's success, contrasting so strongly with the downward social mobility of their parents, may be regarded as a threat to traditional modes of

authority in the family:

Ludmila says:

When we had just come here, we were not afraid of difficulties. Instead, there was a very strong sense of solidarity in the family. It is not like we would never have quarrelled, but we just had this feeling of friendship in the family. When we came, the children were teenagers, very tough age. They were stressed. But now, they are doing fine, they are doing much better than me, they know the language, they make their way better than us, parents. And I notice that I am losing authority. I feel it myself, that they know more than I do.

Marina:

I know, our children have it very difficult. But they have managed to find a way. They know what and how. And us...Like, I would like to do more for my health for example, go to a swimming pool. But it is so difficult for me! I stress out the day before, because I do not know what to do in the locker room, how I will look there... And they just go and do it, one-two-three, ready! I feel a bit silly when I think of myself compared to them.

Two excerpts from Ludmila's account of her family also can be contrasted with each other to demonstrate this ambivalent understanding of success in the younger generation. First, she speaks of the downward mobility experienced by her generation as an inevitable, imposed process, a part of new life, that needs to be taken as it is. She considers it unfair, but also believes that children can compensate for the failures of their parents' generation by working twice as hard:

My husband, he does not work. Or he does odd jobs at construction sites. I mean, it is ridiculous that a person with his head and education must do it, but we were ready for that. We understand. I mean, imagine some Turkish guy, for example, coming to Russia now, it will be the same. Strangers always have it difficult. So, we only hope for the best for the children. They are our greatest hope and concern. They try very hard, and we help them.

At the same time, she is willing to limit manifestations of children's integration at home:

I mean, a lot of it is just language. They speak perfect German, I do not. And I ask them not to speak German at home. Parents and children must understand

each other.

Whereas older generations strongly encourage children's attempts to integrate into the receiving society by means of individual pursuit in the public sphere, they insist on preserving the existing intergenerational hierarchy 'at home'. Marina gives an account of visiting friends, whose children grew up in Germany. She complains of their disrespectful behaviour towards the older generation ('they interrupt you when you talk', 'they are very loud'), and finishes her account by saying:

I don't know... May be this is what is necessary here. But then, behave like that outside, in the streets, all right. But at home, be so kind, respect your parents.

To a great extent, Russian German interview participants denounce 'local' modes of intergenerational behaviours. Petr speaks of his own children as 'well bred' and opposes them to 'uncultured' German youth:

It is not like German young people, you know. These have no sense of respect for their parents at all. I mean, when we were young, we also had our parties and everything, but we have always made sure we do not disturb anyone. That we behave with respect. And they do not care about anything, I think. They schmooze in the streets, in front of children and the elderly, and they just do not care.

Emma says:

The children here, they are just spoilt. With us, ok, there had been a bit of spanking, but children knew their place. You could expect help from them. They knew how to behave. And here I walk down the street and I constantly hear children crying or throwing tantrums. I am amazed by it! It was not like that with us. Mothers spoil their kids here, they [Germans] have much less connection with each other.

Unemployment and poor command of language make the post-figurative structures impossible: parents are pressured to learn from children or rely on their help for tasks otherwise carried out by family members with more authority. For example, children translate all correspondence, accompany their parents in the institutional setting and, altogether, manage all bureaucratic issues, so central in the life of unemployed persons fully dependent on welfare-paying institutions.

Gender roles also transform throughout the migratory process, which some persons also see as threatening to Russian German identity. Irma's daughter-in-law left her son in Germany. Emma says:

Our girls, our women they get very spoiled here! They come here and they want to be like German women. They want to wear short skirts and they tell their men that they may leave them anytime. They think they are independent! But in fact they just behave like whores [bljadi - a tabooed Russian word]. And then, they start leaving their men and families collapse!

Emma says that when her daughter-in-law left, she stopped all interaction with her. She even says that she has taken her pictures out of family albums and cut her from group photos. However, a few years later she changed her mind, because, as she says, she missed the grandchildren, and re-established the link. The women talk on the phone once in a while now. Her son, however, is not in contact with his former wife.

Along with extended family, toil and diligence, two other central values of the Russian German identity are challenged by unemployment in the middle-aged generation. Hard work as a component of life-as-it-is, on the one hand, is regarded a source of illness, as I have discussed in Chapter 4. However, being a core part of Russian German identity and major component of the identity boundary to 'others', it is also a resource of a 'healthy' life, inasmuch as one is able to draw accomplishment and satisfaction from the fruits of her own labour. This is particularly true of agricultural labour, which a few research participants from a rural background refer to as 'a source of health'.

Tanja:

I think, if I knew how it would be here, I would not have come. I have nothing to do here, these jobs in a supermarket or whatever, it is so unstable and boring, I am fed up with it. In Kazakhstan we had a plot, I grew vegetables, and then we had a market stall. I was selling our crops, and it was great, I was always busy! Here I feel that no one needs me, I am deteriorating.

Marina:

The worst thing is, we have no jobs. I mean, I understand we have an education which does not fit into this system here, but we are young! We need an occupation to feel needed. Who cares about us, our children, and that is it. Our

lives seem to be wasted. What kind of health can one have then?

Petr:

Health! You know, back in Kazakhstan there was no time to think about it. Pain or no pain, you go to work! And here I have nothing to do. And then you start noticing, it hurts here, it hurts there, and suddenly, you are an old man.

Welfare benefits meant to compensate for lack of work, in fact, only further threaten Russian German identity: the 'undeserved' income is destroying the tradition and is regarded as unhealthy. Many persons I have spoken to express criticisms about the demoralizing power of welfare dependency and its bad effects on health. An excerpt from interview with Irina can, perhaps, illustrate these beliefs best.

Irina and I sit in a Russian restaurant where she works. It is a popular, rather expensive, place in an upper-class neighbourhood, where Irina travels all across the city to take half-day shifts between her courses in the university. She has just finished her shift, one can see how tired she is, her eyes are somewhat puffed and the makeup is smudged. The senior waiter brings her tea, nods to me in a friendly way and chats with Irina for a minute. She seems to be respected by her colleagues. When he leaves, she tells me about her family. In spite of tiredness, she sounds very uplifted and proud:

Both my parents work. Of course, you know, it is not a kind of work they did in Kazakhstan, it took them a while to learn the language. But, I must say, we are not like some people who just live off welfare. We must work! In my family no one will be living off the German state. Of course, for a while we had to, when we just came, but my parents started working as soon as they could, even if they had to drive a truck or clean other people's toilets. Main thing, it is their money. They don't owe anything to anyone. And I am the same.

I ask her about the 'others' she mentions, and she says:

There are people who have a party every day. Especially, the beginning of the month [when the welfare is paid]. They drink all night, they smoke, they take drugs. They do not want to do anything about themselves. They call the welfare 'life stabilization' and are happy with it! I cannot see that! It is young people! They just waste their lives, instead of working they are stoned all the time. The German state did them a favour letting them in and they are just shamelessly abusing it. I mean, I understand when old people have no jobs, all right, at least they worked all their lives back home. But the young generation, they piss me

off.

Lack of paid occupation and changes in generation and gender roles do not only erode traditional *structures* of family and employment, they are also threatening inasmuch they cause *individual behaviours* conflicting with the core of Russian German identity: alcoholism and violence (attributed to 'Russians'). For example, when sadly reflecting on her status as a single widow, Emma says:

I would be happy to get married again here, you know. But they all drink. Get money for nothing and drink. What a shame! When I was a girl, my mother was begging me not to marry a Russian. Go, marry a German boy, she would say, at least he will not drink, like a Russian!

Mikhail, when talking to me of his almost 40-year long life with Larissa, tells me:

I love my wife! She is the best! And she knows, I do not drink a drop and would never, ever hit her!

Larissa, a few minutes later, speaks of their neighbours, another migrant household in a Marzahn block:

They never work, they drink, and they shout all these swearing words all the time, and smoke on the balcony all day long. It is a shame such people call themselves Germans! They are not Germans! Germans should be ashamed to behave like that.

The combination of broken family ties with unemployment is reflected upon as provoking illness by several interviewees. The two cases below provide a particularly vivid illustration.

Irma came to Germany about fifteen years ago from rural Kazakhstan. Her husband and two adult sons with their families came along. They settled in Marzahn, not far from each other, surrounded by people they knew from their village: everyone has left to Germany, Irma says. Soon after they arrived, her husband died, then the oldest son started drinking heavily, and his wife left him. Three years after, he got involved in a violent fight and was imprisoned for manslaughter, being released just a few months before I met Irma. As Irma and I sit down for tea, he breaks into the flat and starts asking for money, violently. He is drunk. They shout at each other, and as he breaks a plate or two, she gives him five Euros, and then he leaves.

I cooked lunch for him, - she explains in an upset voice, - that is why I opened the door. I would not have let him in otherwise, but I know he is hungry. He was not like that before. When we lived in Kazakhstan everyone knew that Sashenka was a good person. He has very good hands, he would fix everyone's cars and tractors, you know. It all started when we moved! It is all because his wife left him. A man needs a woman. It has always been like that and it is how it should be. Since then he got nuts! He is ill, he is a mentally ill person, he must be put in a madhouse!

I ask her whether he had been drinking before migrating to Germany.

Oh, - she replies, - not really. A bit, on vacation or on holidays. You know, we, Germans, we do not drink like Russians. That he is a drunkard now, it is because he has no job and no wife.

It is a story I hear in yet another Russian German single-woman household, just across the road. Emma has also lost her husband, and her son was left by his wife. Similarly to Irma's son, Emma's son drinks heavily and shows violence towards his mother, as she sadly confesses.

It is because he is jobless, or he has to take those horrible one-euro jobs (jobs paid at a rate of one Euro per hour, which some welfare receivers are obliged to take, - P.A.), like truck driving, and it is just so hard! He works shifts, half a day at the construction site, driving a truck with concrete. Is that easy?! We are very hardworking, you know, we Germans, we know the price of labour. But we never worked like that there (in Kazakhstan, - P.A.), here they squeeze you like a lemon and throw you out. He is constantly ill because of that. He comes to me and says, mother, my back hurts, my arms hurt. So he drinks to relax, as he says.

Unemployment or pressure to take unstable and dangerous jobs results, in Emma's opinion, from the 'ruthless' German labour market:

We have always worked hard. It is in our blood, we Germans are very hard-working. But we have never worked like that, under such merciless conditions.

Russian Germans feel that families and traditions are threatened by unemployment and the new generation and gender roles with which migrants were unfamiliar in their sending countries. It is the return to the realm of steady employment and extended post-

figurative families that Russian German interview participants see as a solution for problems arising in their lives and threatening the coherence of their existence. Set against these challenges, tradition based on collective labour carried out by the household strongly determines help-seeking practices of many Russian German persons, as I will discuss in the next Chapters.

5.2.3 Cross-boundary similarities: gender roles

In most cases, the role of family healthcare experts is performed by middle-aged women who legitimize others' sick roles and shape their performance. Indeed, one of the most important health beliefs in post-Soviet Russia is that 'health is not a man's domain' (Pietilä, Rytönen 2008). It does not mean that men do not provide care: in families I have interviewed spouses of both genders spoke of men performing a variety of tasks related to care giving, however, they were not expected to make choices, and those tasks were mostly assigned by women.

Such a distribution of generation and gender roles is not specific to post-Soviet society only, however, research in other countries demonstrates that in former Soviet families they can be expressed more strongly than in families determined in these studies as native (Remennick 2001; Benisovich 2003; Remennick 2003). It is women's job to allocate resources and delegate tasks to younger members of the family of both genders. They make choices about changes in nutrition necessary to improve or sustain health, arrangements regarding daily care and the need to seek professional help. Even though some male interview participants mocked their wives for 'putting them on a diet' or 'pushing them to doctors', they generally accepted their spouses as decision-makers and managers of choice. For example, several men interviewed in the course of fieldwork fully relied on their wives making doctor appointments for them, on buying and administering their medication and on giving assignments to ambulant nursing care professionals (*Pflege*).

Women make doctor's appointments for their husbands and other family members, accompany them to the doctor and inform themselves about their illnesses from all possible sources. The younger generation often interprets at medical encounters. For example, in Julia's and Larissa's families alike, the appointment schedule for chronically ill husbands was fully supervised by the women. Talking of illness episodes related to seeking outpatient help, men refer to their wives as 'pushing' them to the doctors. For example, Joseph's account of help-seeking in the case of a heart attack starts with him feeling unwell on the way back from a family holiday in Spain. In spite of pain, he took the flight home, and the next day thought he was feeling better, and there was no need to consult a doctor:

Joseph: I would not go to a doctor. I thought, I was all right by then.

Julia: But I insisted...

Joseph: Yes, but she insisted, thank God. She dragged me there! (Laughs)

Julia then tells of making a series of appointments, accompanying Joseph to different specialists and orchestrating the whole family life to enable his treatment, with daughters doing the translation when necessary.

When Julia's elder daughter developed anorexia, it was also Julia's task to locate necessary healthcare providers and gather information about her condition. In fact, Julia even joined a self-help group, which she attended accompanied by her younger daughter, who translated for her.

Larissa also runs Mikhail's appointments, chooses his doctors by consulting other migrants or asking other healthcare professionals. She is permanently pro-actively seeking information and trying to obtain extra care for her husband. The strain that the need to supervise Mikhail's treatment put on her results in her own poor health: unable to find time for her own health issues, she was hospitalized urgently for surgery.

Indeed, females who feel responsible for making health-related decisions on behalf of their families have spoken of the strain they had to bear in that respect, however, they did not principally disagree with the division of roles. Instead, they discussed the alleviation of logistical difficulties in providing care, whereby some elements of German 'abundance', such as nursing care, state-sponsored wellness activities, and the availability of other institutional forms of material assistance featured as important (as will be discussed in more detail in Chapter 7).

The effects of gender-specific roles on help-seeking behaviours will be addressed in more detail in the last two Chapters of this thesis.

Summary

Several conclusions can be drawn from the discussion in this Chapter.

First, with respect to social mobility, I suggest that the decisive role belongs to involvement in a specific type of migratory process, as discussed above: whereas self-funded migrants integrate into the labour market relatively easily, the institutionally-funded are often unable to find employment and have to draw on social welfare. These processes are influenced by different types of social networks and resources distributed through them.

Second, the collective experience of downward social mobility is perceived by migrants in the context of external stigmatisation. In response, identity boundaries emerge, whereby different categories of migrants re-invent themselves in terms they consider to be immanent to their cultures. Families of former privileged intelligentsia continue their pursuit for *kul'turnost*, conceptualising their aspirations as westernisation and shrugging off the socialist past. The flexibility of their pre-figurative family structures provides them with a basis for less conflict-ridden integration into the new society than in the case of Russian Germans. The latter, formerly disadvantaged or fragmentarily empowered families feel threatened by the challenges of their new lives, fearing erosion of generation and gender roles as a result of unemployment and related loss of traditional forms of authority. Whereas Jewish migrants blame Russian Germans for the overall lack of *kul'turnost*, the insiders are mostly worried about the deterioration of tradition. For Charlottenburgers welfare-receiving unemployed migrants are *nekul'turnie* (uncultured) because they do not demonstrate a willingness to westernise themselves; for Marzahnners they are *uncivilised* because they are not fitting into tradition and are jeopardising common identity.

In spite of great differences across migrant communities, some similarities can be observed with respect to generation and gender roles in nuclear families, with women equally considered to be the main care providers in Jewish and Russian German families alike.

The discussion of transforming statuses and identities presented in this Chapter provides the basis necessary to understand migrants' ideas about the effects of migration on health.

In the next three Chapters I will discuss migrants' conceptualisations of migration as a process affecting their health. I will demonstrate that, in spite of downward social

mobility, many persons believe that they have benefited from migration, and attribute positive changes in their health to some aspects of life in Germany. Also, I will discuss how 'traditional' and 'westernised' identities relate to the adoption of new help-seeking practices.

Chapter 6. Transition to the world of plenty

The salad Tamara puts on the table in front of me while I am taking my recorder out of the bag and preparing to take notes, perhaps, could symbolise everything migration means to health for persons I have spoken to: facing the world of plenty, trying to adapt to new ideas about what is 'healthy' by ceasing to be a 'Soviet' person, and adhering to tradition. Let us take a look at this bowl: what are the ingredients?

There are tomatoes, sliced carrots, sweet corn, cucumber, dill, lettuce and a lot of mayonnaise.

- Have some salad, - she insists, - You know, we are very selective about what we eat. I cook everything myself, like back in Moscow. Home food is the best, it does you good! But we do try to eat a lot more vegetables here, it is just so easy, everything is in the supermarket all year round, not like in Soviet times. So, I can say we maintain a healthy lifestyle.

It is January. Fresh tomatoes and cucumbers in this salad stand for the ability to buy anything you want all year round. Tamara giggles, quoting a famous gag by a dissident Soviet stand-up comedian Mikhail Zhvanetsky:

Remember that one, don't you? Like, our guy asks a relative who had emigrated to the USA, "when do you have strawberries?" "Strawberries? From six o'clock onwards in a supermarket!" We laughed our heads off about it back then. Six in the morning! Strawberries! That was dead funny to us!

The reason the joke is funny is based on two facts: Soviet shops would not open before 9 or 10 am, and, certainly, strawberries were not to be bought there all year round. Tamara continues:

And now I wonder what I found so funny about it. It is like, so what? I go and buy what I want, any time.

Tamara's words suggest that migration has enabled a transition from the world of shortages into the land of plenty.

Another person of Tamara's age, Eva, an elderly Russian German from Moscow,

also says: 'Germany is the country of plenty'. The expression she uses, in fact, means literally, Germany is a well-fed country (*sytaya strana*), and she employs it in its direct sense:

When I first came here, I was shocked! I saw half-eaten bananas or apples in the trash bins in the streets, and I could not understand how one could just throw them away. It is unconceivable to me even now that they throw bread away when it goes stale.

In interviews with former members of the intelligentsia, that is, persons with a more privileged background, endless shortages in the former USSR are reflected upon as a manifestation of a failed political system, and one's attempts to compensate for them by private means constitute a kind of grass-root dissident behaviour. Indeed, given the ideological importance of rationing to the socialist economy, individual consumerist strategies acquired great symbolism. The remark about strawberries being available in American supermarkets, for example, acquired the character of a political anecdote in the former USSR (and this is the context in which Tamara discusses it). Another famous Soviet Jewish comedian Arkady Raikin, a figure whose meaning to the Soviet urban intelligentsia can, perhaps, be compared to the one of Woody Allen to modern intellectuals, had a well-known performance, whereby he silently walked onto the stage wearing a sheep-skin coat and a pair of jeans, holding a net bag with a pineapple, a jar of caviar and bananas in one hand, and a pack of toilet paper in the other. The comedian stood on the stage without saying a word, while of the audience's laughter increased every minute. He would leave, followed by great applause: his admirers would not need any verbal commentary; each object held or worn by the actor signified the discrepancy between the promised heaven of communism and the reality of never ending deficit. Not only the clothes he wore, but also the food he held in his hands acquired a deeply political meaning: by consuming objects which were not available to everyone, the person on stage demonstrated non-compliance and non-conformism. Capitalist countries, instead, turned into mythological realms of abundance, and their artefacts, such as French perfume, American jeans or a German sound system served as markers of social status. Whereas the urban intelligentsia had familiarised itself with these tokens of 'Western' life long before the collapse of the USSR (by being able to travel, even a little, or by maintaining some contact with the earliest waves of emigrants), rural Russian Germans have only become introduced to material manifestations of the 'Western' good life in the 1990s. A few interviewees, for example, refer to German postal order catalogues (such as OTTO, for example) as their first

introduction to modern Germany (very similar remarks have been collected by Wierling in her project on the Russian German oral history of migration, (Wierling 2004)). Others speak of relatives sending packages full of *things* from Germany, giving people the sense of Germany as a country of abundance. Migration, finally, allowed migrants to consume all those things previously unheard of or having a status of anti-Soviet.

For many formerly disempowered persons, whose identity revolves around hard work rather than anti-Soviet beliefs, migration meant the alleviation of the daily burden. As I will discuss further, such 'simple' things as reliable housing, safety of public spaces and accessibility of public transport are reflected upon with great admiration, gratitude and are considered to be strong determinants of better health.

Hence, the majority of persons feel that migration to the world of plenty has had a positive effect on their health, attributing these effects to the changing conditions of 'how life is'. 'Takaya zhizn' has become better, in terms of material supply. However, whereas those who used to belong to the category of the disadvantaged perceive these conditions as imposed on them, former urban intelligentsia feel that life in Germany enables them to behave as *kul'turnie ludi* and pursue more control over their health by being able to make 'responsible' choices.

But let us go back to Tamara's salad bowl for a second and take another look at its ingredients.

Whereas fresh cucumbers and tomatoes manifest the abundance, unheard of in the sending country, lettuce, rarely employed in Russian cuisine and popular in Germany, symbolises Tamara's willingness to acquire new nutritional habits. She does not serve it solo with balsamic dressing, however, the way a German housewife would. Instead, it sits in her bowl with sweet corn and mayonnaise. She says:

Mayonnaise makes this salad more tasty. It gives it a zest, you know!

Unless the reader of this thesis has spent months in the former USSR, he or she may think it is Tamara's individual culinary extravagance. But, in fact, it is not. In contrast, for someone who has been socialised in Russia or any other European republic of the ex-Soviet Union, all other ingredients of this salad are extravagant and unfamiliar, whereas mayonnaise is *the* reliable life-long companion, sometimes the only inhabitant of the otherwise empty shelf of a local food store. Indeed, it is hard to find a popular salad recipe in Russia which does not include mayonnaise as a dressing. Unfortunately, the limits of this thesis do not permit me to discuss the role mayonnaise, a simple sauce, has acquired lately in Russian debates about cultural change. It would be enough to say that in culinary TV shows, in Internet forums and blogging communities, in urban legends and anecdotes

mayonnaise came to signify the socialist past and socialist habits. To young educated urban Russians, lunching on sushi and rocket salad, mayonnaise is the beginning of a cultural war-zone. Tamara, however, is unaware of this debate in her motherland. She uses mayonnaise because she has done so all her life. She follows the tradition, combining it in one bowl with her feeling of achieving a better life and doing good to her health.

This Chapter will analyse migrants' beliefs about Germany as the land of plenty, and about the effects of migration on health. It will address migrants' conceptualisations of three aspects articulated in interviews as major determinants of health: natural environment, housing and nutrition. I will discuss differences in the understanding of these health determinants across groups of migrants, linking them to their backgrounds and identities.

6.1 Natural environment. The Air We Breathe

An indisputably positive development, attributed by all migrants to the external circumstance of their lives (,takaya zhisn'), is the natural environment. The better 'air we breath' as a reason for improving health is mentioned by Marina from a Kazakh village and by Paul from a Ukrainian city, by wealthy Lena and by unemployed Ludmila, by Jewish Inna and by Russian-German Irina.

The only two persons who have not spoken of change in the natural environment as factors which affect their health, are Boris and Misha: two men who were brought to Germany as teenagers and have little memory of their life in the USSR (in their own words). This exception may help understand the awareness about the natural environment in other migrants: they come from a country which was notorious for destroying nature, and they lived with the after effects. Besides, they moved into a country where awareness about natural environment is a traditionally strong political issue.

Interview participants mention different kinds of environmental pollution they had to deal with: acid rain, polluted water and air, exposure to dangerous elements at work. For example, Irina says:

Of course, it is just the life itself that is so much better! Just think of the natural environment. I shiver when I think of all the chemical industry in Kazakhstan, God knows what kind of air we were breathing there, it was polluted to the point of no return. It is so much better here, that the environment alone does you good. In Kazakhstan people get ill all the time because of the pollution, and the doctors refuse to give them sick leaves, it is like, top secret, that the air is bad.

Ludmila also expressed scepticism about the environment in south Russia:

I am very worried about my family who have stayed there. God knows what they eat, what goes into the soil there, and what is put in the groceries, what kind of chemicals...

Lena, who at the time of the interview travelled a lot to Moscow with her family, was also very unhappy about the state of natural environment in the Russian capital:

I go there, and I start sneezing, my eyes are itchy, I feel terrible. One cannot breathe there! It is all dust and gas.

During the research process Lena got pregnant with her third child. Although Lena's husband was permanently based in Moscow with his employer, she spends half of her time in Berlin where she has lived for ten years, and where her parents now live permanently. Lena's husband is a high-ranking investment banker, and as an adverse event occurred to her in the first trimester of her pregnancy, she was immediately placed in a Moscow private clinic and offered the opportunity of giving birth there. However, a few months later she came to Berlin to undergo a few remaining pre-natal observations and to give birth in a 'normal' state hospital, covered by her German insurance. Not only did she feel that German medical care was better (as discussed later), but she argued that her main motivation was to leave Moscow due to its 'poisoned' air.

I cannot imagine being there with a newborn baby! Where will I go for a walk with him? There are no trees anywhere, the air is poisoned, and no place to hide from the heat. In Berlin I walk out of the house, and I breathe with a full chest, I can be sure it does not do my baby bad. There is no way I could stay in Moscow!

Altogether, migrants in all groups have demonstrated an ability to estimate the negative environmental effects on their health, however, none of them spoke of their own ability to bring about positive change by, for example engaging in environmentally-friendly consumer practices. In that respect, migrants with lower levels of education and with a less empowered background differ little from native Germans comparable in status (none of the persons in Marzahn, with the exception of the Meiers, raised this topic). However, a significant contrast between migrants and natives can be observed in better educated groups: whereas native Germans expressed awareness about the environment and the need for individual effort, migrants were quite convinced of the uselessness of individual attempts to preserve nature. I will discuss this discrepancy in more detail in Chapter 7 when analysing migrants' and natives' attitudes towards organic nutrition. However, some persons from formerly privileged or fragmentarily empowered backgrounds who described their health in terms of *kul'turnost* spoke of environmental pollution as a strong push factor. Irina says:

For us, for my mother, environment was the greatest issue. It was impossible to stay in Kazakhstan, we were seriously endangering our health. So, the air we breathe now, this alone is a great outcome of our migration.

Being able to exercise at least some degree of control over other spheres of their lives, these persons conceptualise the negative effects of pollution on health especially strongly. The only thing a *kulturnij chelovek* can do about pollution, they suggest, is to leave, that is, pro-actively seek a different life in another country. In particular, this concerns the better-educated, urban Ukrainian population who suffered from post-Chernobyl radioactive contamination. Although Chernobyl after effects have been conceptualised in some literature as being among the most important reasons for the collapse of the USSR (Alexievich 2005), so far no coherent research has been conducted about its effect on migration from the former Soviet republics. Radioactive contamination as a reason to leave was mentioned in 8 interviews (with former Kazakhstan and Ukrainian residents). People's awareness of the disaster and their wish to leave its site is especially pronounced in cases of:

- Ekaterina, who believes that her MS is a direct result of the nuclear disaster.
- Mikhail and Larissa, who mention it, among other factors (poverty, loss of social support, political instability) which made life in their city no longer 'possible'
- Paul, who puts it into a general context of a deteriorating state, along with political and economic instability;
- Inna, who felt that the health of her family started deteriorating from 1986 ('permanent headaches and feeling of weakness'), and that it 'was necessary to leave'.

At the same time, one must take into consideration the effects of Chernobyl on Ukrainian identity. Adriana Petryna (Petryna 2002) demonstrates that the external categorisation of 'sufferers' and 'survivors' as determined by policy makers and international mass-media to Ukrainians has caused the construction of 'ill' and 'disabled' selves: a stigma necessary to draw on scarce resources of the impoverished society.

In interviews with persons from the least empowered backgrounds, environmental pollution is never mentioned as a push factor, however, it is often discussed in comparison to life, taken 'as it is', in the receiving country. Marina says:

Soon after we arrived and got settled in the camp, we went for a walk. And we ended up in the cemetery. We saw the tombstones, and were shocked. How long did people live here! With us, 60 would be the end. We come from such a contaminated zone, that none of our relatives actually made it to pension age. And here, all these old people, they look so well and they live long. So, maybe there is a chance for us too...

The quality of the natural environment as a public good contributing to a positive

effect on health is conceptualised by migrants across all groups and backgrounds, as it is in German society at large. Such a consensus, however, is rather untypical: as I will demonstrate further, conceptualisations of other aspects of new life-as-it-is are characterised by a stronger socio-economic status and are more directly related to identities.

6.2 Housing. Hot Water 24/7

Conceptualisation of positive change attributes a significant effect on health to improved housing. Unlike the natural environment, however, housing is not universally understood as belonging to the external circumstances of 'how life is'. Whereas the formerly disadvantaged persons, indeed, attribute better housing to the German 'grace', those with more empowered backgrounds tend to estimate the effects of housing on their health in terms of individual achievement and pursuit for control. Besides, housing as a realm of change is not reflected upon by migrants in Charlottenburg, with the exception of Irina, who comes from an industrial town in Kazakhstan. All other accounts of housing as a health-related factor have been gathered in Marzahn. Perhaps, this may be explained by the lesser degree of contrast between 'here' and 'there' as experienced by former urban Jewish intelligentsia, in comparison to persons from less privileged regions.

Russian German migrants from rural Russia, Ukraine or Kazakhstan discuss how life in Germany has entitled them to commodities which could not be taken for granted prior to migration. Accessible and comfortable urban infrastructures, such as housing, shopping facilities and public transport make up a body of 'positive' health-affecting material change. Altogether, a narrative of positive change in living conditions comes from residents of apartments in Marzahn high-rise blocks, with the exception of Irina, a young Russian German woman who lives in Charlottenburg. Other Charlottenburg residents did not raise this topic.

Migrants in Marzahn apartment blocks tend to conceptualise the positive effects of change in housing as compared to the sending country in terms of reduced household work-load. Most of them are either pensioned, or unemployed, or taking on irregular manual jobs. Discussing the positive effects of housing on their health, they talk of not having to 'strain themselves' (*ne nado naprjagatsja*) or worry (*ne nado ni o chem bespokoitsja*) in order to perform mundane, everyday chores like cooking, shopping or doing laundry. They refer to housing as an important component of their lives, taken 'as they are'; housing is embedded in the context of everyday work, and may either serve as a resource of additional labour (like in the sending country), or is, on the contrary, a refuge from an otherwise tough life:

Ludmila says:

Life itself is just much better, much easier here. Here, for example, I have hot water 24/7, all year round. It was not like that in Russia! I just turn on the tap,

and here it is. Maybe, some other people think this is how it should be, by default. But if you tried living without water, when you turn on the tap, and there is nothing, then you know the difference. So, I am not afraid of anything anymore.

In fact, Ludmila, who has a long and complex medical history resulting from a car accident, attributes her ability to walk, do some light household work and sometimes even go out in spite of severe physical limitations, to the overall good living conditions in Germany. For a long time she has not been receiving state-funded care and household support services, because she did not know she was entitled to them (her strategies of reliance on personal networks for help will be discussed in Chapter 8). Still, she insisted that *'life itself is so much easier in Germany, that I can cope'*.

Marina speaks of similar issues:

Here the life itself is just different. Everything is just so convenient here, so well thought of! For example, when we moved into this flat [in a council building], we just entered, and everything was already there. Here is the blanket, there is the cutlery. Nothing to worry about!

Emma:

Materially, I think, I am doing very well. I have a nice apartment, it is clean, I have an elevator and a balcony. I don't have to carry anything heavy upstairs, it is really wonderful! What else can I ask for?! I feel very good here!

Albert and Nina are also very satisfied with their housing. Albert says:

It is just that life itself is very different here. When we first came, we were astonished with how good life was here. We could have a very good flat, and now we could even move to a better one because we wanted a balcony. It was all possible! Even though we are just pensioners.

Nina adds that in Kazakhstan she

had to do all the washing, all the laundry by hand. And here I have a washing machine, so I do not have to bend down over the basin and rub till my skin is raw. And now that we have a balcony, I can also hang the laundry outside, so that the air in the flat is not damp.

Larissa:

The main thing here is that there is an elevator in the house, so that he [husband] can go out. You know, with his feet it would be impossible otherwise. But with the elevator he goes out every day, gets some fresh air, and on a good day even goes to a supermarket. It does him very good!

Irina, who lives in Charlottenburg and belongs to the youngest generation of Russian Germans I have interviewed, also conceptualised her housing situation in the context of hard work:

What I like my home for, it is quiet here. I only wanted to live in an Altbau because it has thick walls and spacious rooms. One of my windows faces the back rear wall of the house, and I am very happy about it. I never hear a sound from the outside. After you have had a shift in the restaurant, with all the clients, and the kitchen noise, you just want silence and nothing else. Home is the only place I can really rest. I feel physically better after I just spend a day indoors.

Having undertaken most interviews in people's homes, I was regularly give tours of Russian German Marzahn-based flats, proudly pointing out the balcony or kitchen appliances. For residents of Marzahn, the apartment blocks, convenient housing, equipped with household utilities, is a very strong determinant of the overall improvement of life-as-it-is and is conceptualised by them as having a positive effect on their health. For them, a comfortable house is a material manifestation of a sturdy family, a place where everything functions on all levels.

Similar reflections of on the change in housing were expressed by former GDR citizens when they spoke of moving from post-war central Berlin into newly built houses in the East. For example, Maike says:

Our son, he is a different generation. He lives in Friedrichshain (an up-and-coming neighbourhood in the former East Berlin, composed of old houses - P.A.), and he likes it. We used to live in Prenzlauer Berg [a former GDR neighbourhood, which has recently undergone significant gentrification] ourselves but back then it was all about coal-fired ovens, toilets on the stairwells, etc. It was horrible. We were very happy to move here, to have central heating and double-glazed windows. Nothing will make me move back in the centre, I have no regrets. Here I can always walk out on the balcony and look at this amazing broad view in front of my eyes. It is spacious here. And there is a little forest just around the house, so that the air is always fresh, and you can go for a walk any time.

In this context, two migrant households with private houses in Marzahn strike a

strong contrast with the migrants in apartment blocks when discussing the housing situation and its effect on health. Belonging to the formerly ‘fragmentarily empowered’ and privileged categories, these persons tend to attribute health to *kul’turnost*, rather than ‘taking life as it is’. They believe that the ‘others’ in the apartment blocks live ‘unhealthier’ lives than themselves. The only German household in a private house interviewed, the Maiers, also insist that they ‘do not fit in’ with their German neighbors.

Galina says:

We used to live in a apartment block here, it was a good flat, but of course, the kids did not have much space to play, and taking them to a playground takes a lot of time. As a result, we were staying in far too much, and it is not good for them. Here they can just hang out outdoors all the time, it is excellent. And we have built a banja [a Russian sauna]! Banja is such a resource of health [istochnik zdorovja]! Whenever someone catches a cold, they are sent to banja to sweat, and next day they are healthy again. It is very good for everything, for the immune system, for the circulation, you name it!

Viktor, who I interviewed as an expert, moved into a house for professional reasons: it permits him to maintain his psychoanalytical consultancy and live on the same premises. A brief tour around the house followed the interview, whereby he proudly showed me a garden plot and a spacious living room:

It is such a pleasure to live here, in the house! In the apartment blocks people are squeezed like herrings in the jar [kak seledi v bochke], they sit on each other’s heads and hear every noise that comes from the neighbours. For our people it is especially bad, I am sure, this is one of the reasons they become depressive and develop all sorts of psychological problems. They are peasants, they need space, soil! These flats are claustrophobic for them.

The Maiers also regard their housing situation as a core resource for their health: they stress the importance of outdoors activities for children and the ability to grow their own fruit and vegetables as the greatest health benefits of their own housing. Similarly to migrants in private houses, they somewhat demonize life in concrete blocks:

Stephan Maier:

How the people in high-rise buildings live, we don’t know, we have nothing to do with that. It is a different world to us, these concrete prisons, I don’t know, we

kind of don't even come close.

This difference in understanding of housing and its effects on health is likely to be related to the means by which housing had been obtained. Migrants in the apartment blocks had little influence on their housing situation, given that their choices were severely limited by welfare dependency. In fact, when talking of 'obtaining' their flats, many persons use the passive voice: they talk of apartments being 'given' (*nam dali kavartiru*) or 'assigned' to them (*my poluchili kvartiru*) by the local councils. Thus, housing, like other aspects of life conceptualised by migrants as health determinants, is perceived as imposed.

In contrast, those who live in private houses went to great lengths to be able to move into their property and make it private. Sergei did most of the construction work himself; Viktor had to work very hard for several years in order to receive a mortgage; Stephan had to engage in a long trial with the German state authorities in order to re-claim the property which used to belong to his parents in the GDR times. In this view, housing is not more imposed on one as a part of taking life as it is; but rather, a house of one's own (as compared to a flat), is a project one accomplishes to make one's own life better and healthier. Maintaining a house is a part of individual effort for health, which is so central to the concept of *kul'turnost*.

6.3 Nutrition. The plethora of (plastic) tomatoes

The history of the USSR, up until the end of the World War Two, was marked by several subsequent waves of famine, and regulation of food supply was a significant instrument of the Bolshevik politics, historian Tymothy Snyder argues (Snyder 2011). Years, following the collapse of the USSR were also marked by food shortages, in some regions strong enough to motivate people for migration, as discussed in this section. Chapters may suggest. Hence, reflecting upon the effects of arrival to Germany on health, many interview participants spoke of being transplanted from the land of shortages into the world of plenty. For many people, this change signified a shift in dominating discourses of healthy food: from 'quantity' to 'quality'. Others, in the contrary, claim their superiority by suggesting they were familiar with 'Western' understanding of food prior to migration. Altogether, the findings of this thesis concur with Lupton's summary of dominant discourses which are commonly used to organise people's ideas (Lupton 1997: 448):

... '[T]rying' to consume the 'right' kinds of foods, the importance of 'balance', the notion of food as 'functional' for bodily health, the 'blame' that often accompanied moral judgements about the diet of people with serious illnesses such as cancer and the 'battle' and need for 'control' that people with children referred to in relation to making sure that their children consumed a healthy diet.

In this section I will analyse how ideas about health food transform throughout migratory processes and come to encode changes in identities.

Migrants in all socio-economic categories and sharing different health beliefs believe that migration to Germany has meant a quantitative improvement in nutrition. The supply of groceries in German stores is seen as significantly larger in scope than in the USSR and its successor states. Upon migrating, persons who have lived with permanent shortages of foodstuffs and developed complex strategies for overcoming them, have access to products they have never seen, tried or even heard of before. Not only are these groceries available from any supermarket shelf, they are also considered to be affordable, even by those migrants who are unemployed and need to rely on social welfare. Thus, unlike the housing situation or the state of the environment, nutrition is regarded by many persons as a realm of direct individual agency.

On the one hand, availability of anything one may need food-wise is one of the

most important improvements to 'how life is', and so represents a strong determinant of reduced psychological and social stress:

Emma:

I can afford anything I want, I have nothing to complain about. If I want this cheese today, I will buy it, if tomorrow I feel like a different sort, so what, I can buy it, too. There is nothing to worry about! I live very well.

Marina:

Even with the little amount of money we have, we can afford more than back home. Simply because in Kazakhstan it was not there! If you calculate your money properly, you can try a lot of different things.

Kristine:

We are very satisfied with our life. We have nothing to worry about! We can afford anything we want, even with our pensions. In the supermarket I can choose between this or that, and if I don't find it in this one shop, I will go to the other.

Perhaps what each of those persons has experienced at different times in their biographies, when first entering a German supermarket, had been a collective experience for former GDR citizens: some of the former GDR interviewees also reflect on shortages of groceries (Stephanie, Jonas and Stephan) and their excitement with the assortment of goods in West German grocery shops. However, in comparison to former East Germans, many migrants from the former USSR conceptualise and highlight the *quantitative* change in grocery supply in a significantly more pronounced way, especially the formerly less empowered.

On the other hand, the quality of available foodstuffs is questioned by migrants in all groups, their various concerns, however, being a reflection of their different identities and socio-economic mobility. Many Russian Germans, with formerly disadvantaged and fragmentarily empowered backgrounds alike, consider some categories of groceries sold in German stores as 'unnatural', 'full of chemicals', 'plastic' and 'unhealthy': vegetables, meat and poultry are considered to be of especially questionable quality.

Kristine:

The sausage in the shop, who knows what they put there. We do not buy it. To

make a good, healthy sausage, I buy a good piece of meat and make the mince myself. The mince in the supermarket is too fatty, it is not good. And then, I make my own sausage, it is much better in quality, much healthier.

Albert:

We made sure we got a garden plot very soon after we came here. So we can have our own potatoes, for example. I think the stuff they sell here in the stores is totally unnatural. And it tastes so much better when you grow it yourself!

In fact, migrants question the nutritional and health-related qualities of the foodstuffs they used to produce themselves in their sending countries: the criticisms come from persons who used to maintain livestock and were involved in daily agricultural labour; they do not compare groceries in German stores to the ones in Russian, Kazakh or Ukrainian shops, instead they compare supermarket food to self-grown. In that respect, it is important to bear in mind that in the former USSR many persons based in the cities still participated in subsidiary agriculture, especially in the 1990s

The health qualities of food are attributed to one's personal control over the production cycle: in contrast to groceries of which one does not know 'where they come from' and 'what was put in them', the self-grown ones are produced with one's 'own hands' and with 'soul'. Excessive choice of food *per se* is not regarded as healthy, moreover, it may come across as confusing. Comparable conceptualisations came from 'local' Germans in the Charlottenburg Altbau apartments and the Maiers, the couple with a private house and garden in Marzahn, the group of interviewees with the highest income and high levels of education. All of them, in fact, do grow their own veg in green houses or large balconies. Similarly to many Russian Germans, they believe in growing their own as a key strategy of healthy nutrition. Either group of interview participants feels confronted by the world of plenty and its non-transparent mechanisms of food production. However, this confrontation results from very different responses. Whereas 'local' Germans articulate their nutrition practices as *rebellion* and place it in the overall political context of 'green' non-conformism, Russian Germans, instead, place it within *tradition* and their identity of hard-working folk feeding the extended families by means of their own produce. Indeed, agricultural labour may be a source of bad health, as many Russian German migrants suggest, talking of aching backs, stiff shoulders and the negative effects of permanent dampness. At the same time, it places one in the community sharing the common lot and able to take life as it is together. Moreover, subsidiary agriculture should not be reduced to

adherence to tradition only. Growing one's own in the former USSR, especially in the transitional years, needs also to be placed in the overall context of shortages of material and social goods. Not only was home produce meant to compensate for empty shelves in the food stores, it also suggested a degree of autonomy with regard to the overbearing and ill-trusted state. In that respect, 'healthy' also means 'independent', and can be regarded as complementary to the overall attempts of the better empowered persons to circumvent the statutory system of provision for health.

Those who come from a more privileged background or identify themselves with it (like Irina, Marina and Galina), also question modern means of food supply embodied in 'plastic' supermarket tomatoes, however, it is not adherence to tradition they cast against it. Persons with an urban background have either not mentioned growing their own as a healthy strategy at all (Ekaterina, Galina) or, in fact, opposed it as 'unhealthy'.

For Marina and Ludmila, two women with higher education coming from poor, rural regions of Kazakhstan and Russia, growing their own is simply a subsidiary strategy, a practice of food production which cannot substitute for a healthier choice. They do not identify themselves with agricultural labour as a 'glue' for the extended family.

Ludmila:

For example, I spoke with my father on the phone recently. And he says, well, we worked in the greenhouse, got our tomatoes, very nice tomatoes this year! And then, I think, right, that means they will not see a single fresh tomato till next summer. People have much, much less demands. They are only used to surviving. (...) The kind of groceries there is just totally different. Everything is very drab, poor in quality. Of course, in big supermarkets there is everything, but you buy this sausage and you do not know whether you should eat it or not. What was it made of, where it came from. People eat very little fruit. At least, in our region you can have some in summer. But then, you have to make an enormous amount of preserves, in summer you have a preserve factory at home.

Marina:

Fresh tomatoes, fresh cucumbers, we only saw it three months a year. And then, all year long you would have it pickled or preserved. So, what is the use of growing it all for health?

Irina who is identifying herself with the *kul'turnie ludi* of Charlottenburg, suggests:

All these babushkas (grandmothers) selling their potatoes along the roads in Kazakhstan, no thanks. Who knows where these vegetables were grown and how much radiation or acid rain they have taken?

Irina is confronting what she considers to be an 'uncivilized' Russian German tradition, attributing it to 'babushkas', old uneducated women in rural Kazakhstan. Instead, she believes, it is one's capacity to make clever decisions and behave as a *kulturnij chelovek* that matters to health. The supply of groceries in Germany is conceptualised in terms of an increased ability to make better, healthier choices. Irina speaks of her initial fascination with the new food:

Of course, first, when we came, we probably behaved like some wild people, as if we came from a starvation zone (s golodnogo ostrova). I remember how mad I was about all these pizzas and cokes, all that stuff.

But then she speaks of the fascination with the sheer quantity of available products wearing out as considerations about its quality arose. Limiting the choice voluntary is her solution for healthy nutrition:

So, you eat all these pizzas in the beginning, but then you start thinking, what is good for you? I do not even touch that stuff anymore. (...) In my kitchen, I only have two spices, salt and pepper. That's it. I keep it simple and healthy.

Identifying herself as a *kulturnij chelovek*, Irina stresses her skills in making choices and being able to select the healthiest products. Others recognise the limitations of what life was in the sending country as prohibiting them from making healthy choices, and express satisfaction with their ability to be more 'responsible' and exercise more choice in Germany: the land of plenty has not just improved their life-as-it-is, it has also given them the chance to behave like *kul'turnie ludi*. Integration into modern capitalist society is greatly dependent on the ability to consume and on the strategies one chooses in doing so. Choosing food and shopping for food is indispensable for everyday life, and choices related to it become highly characteristic of a person's ambitions. For persons who stress *kul'turnost* as a main health determinant, nutritional choices are one of the greatest

indicators of one's personal effort and individual responsibility for health.

Galina:

Here you have fresh vegetables all year round. There is no need to eat potatoes and noodles every day. I make light vegetable soups all the time, and we stay away from pre-cooked meals. Here the choice is so big, you will easily find healthy groceries.

Misha:

The majority of people just stuff themselves to death with trash, and then they are surprised they are not feeling well. People are just very ignorant, they do not want to know what they do to themselves. If you want to be healthy, you must be very selective about food, you must know what it does to you.

For Larissa 'healthy' nutrition also means not buying food from Russian shops: the desire to avoid identifying with her Russian background has a pronounced effect on her nutritional practices. She says she does not trust 'Russians' after having been sold a bottle of what looked like sparkling wine, but turned out to be cheap lemonade. She says:

Now we are in Germany, we are Germans, and we will shop in normal German shops!

For these persons, the main practice of 'healthy' eating is autonomous, informed and involves critical decision-making. For persons with higher education, regardless of their previous background, the transition to the new world of plenty is an opportunity to enhance *kul'turnost*, by changing individual behaviours. Westernization is a strategy particularly important for this individual pursuit.

6.3.1 Eating like a Westerner. Anti-Soviet Food

Eating salad

Consuming fresh vegetables is often referred to in the interviews as 'eating salad' (est' salat): in Russia and the former USSR republics, salad is usually a mix of different vegetables, dressed with mayonnaise, creme frêche or oil, rather than lettuce sprinkled with balsamic dressing. Some kinds of salads popular in the former USSR include meats or cheese, such as the famous 'Russian salad', where potatoes are mixed with veal, sweet corn, peas, boiled carrots (and whatever else a Soviet housewife would manage to 'get' in a grocery store) and mayonnaise. Several interviewees among those who stress *kul'turnost* have spoken of 'eating a lot more salad' since their migration to Germany, meaning, however, not the latter type of salad, but a mix of fresh vegetables. In fact, 'Russian salad' (which is called 'Olivier' in the former USSR, being attributed to a French cook of Count Stroganov) has become a symbol of Soviet nutrition: migrants mention it when casting their new, 'healthy' Western habits against the old 'unhealthy' Soviet ones.

Irina:

I do not make all these Soviet salads, this Olivier, God forbid! Just a bit of fresh vegetables with oil, that is it.

Misha:

Everybody ate Olivier in the USSR. My mom would just put a bit less mayo in it. But my grandma, she was a cook herself, and she ate a lot of normal salad and herbs, and these Soviet people would stare at her like, why, she is like a goat, eating hay!

Tamara, whose salad I have discussed above, also reflects on the ingredients in terms of transition from the past:

I do not put meat in the salad any longer. That was our Soviet habit, when there was nothing to eat. Now we are older, we have to take care of cholesterol, and I mostly use fresh vegetables.

In comparison, none of my German research participants have spoken of eating

fresh vegetables as a healthy practice *per se*; instead, those, who mentioned it spoke of the *quality* of these vegetables (distinguishing between self-grown, bio or supermarket ones, as I will discuss below). This difference in conceptualisation of vegetable intake between migrant and non-migrant interview participants suggests that by highlighting the sheer quantities of 'salad' they eat, migrants, in fact, stress their ability to consume food previously unavailable to the majority of the Soviet population. Indeed, fresh vegetables and fruit, among other things, were especially hard to get in many Soviet cities, especially to the North of the country. In that sense, eating vegetables is a kind of conspicuous consumption: on the one hand, it permits migrants to identify themselves with higher status groups or as Misha illustrates it:

I eat very little meat, almost no meat at all. Mostly fish, and a lot of fresh vegetables. Lots of salad! The way I eat, only very rich people in Russia can afford. Not because the groceries are so expensive, but because they pay a cook, who thinks for them and knows what's good for them.

On the other hand, eating more vegetables and less meat is conceptualised in migrants' accounts of nutrition as a practice of westernisation: they are not like 'other' migrants or persons in the sending countries, who have not shed their socialist past. This is especially true for persons who insist that inclusion of fresh vegetables in their daily diet results not from the changed conditions of life, but from their 'responsible' understanding of health. They stress that 'other' migrants, in spite of new opportunities, continue to eat 'unhealthy' food and do not consume fresh vegetables.

Misha, an outspoken advocate of a 'healthy' lifestyle:

The majority still eats their borsch and pelmeni. And then they grow fat, like pigs, and their heads are just full of crap. (What do you eat when you go out or have dinner at other people's homes?) My friends, they are all normal, educated people. They know what I eat, and they cook some fish in the oven, may be, a salad, something light. I do not visit people who eat trash, I simply do not have such acquaintances.

Sonja:

If I eat meat, I must, I just absolutely must have some fresh vegetables with it. I can't imagine how can you have meat with potatoes or with pasta? It is simply

far too heavy, like something from the Soviet times. If there are no vegetables, I just munch on herbs. (...) It is something my mother taught me. OK, in the USSR vegetables were only seasonal, but still, you could do a lot with them. And herbs you can always get, all year round there would be babushkas selling dill and coriander in the streets.

As I have mentioned above, in comparison to native Germans, migrants stress the quantities of vegetables they consume, rather than their quality. The exceptions from this trend are migrants who buy 'bio' (in German 'bio' means the same as 'eco' or 'organic' in English) groceries conceptualise this practice as 'something done for health', but in a way very different from native Germans: whereas the former pursue an individual ambition to be like a 'Westerner', the latter are hoping 'to save the world'.

Shopping for bio

Accounts of bio food appear in all bar one interview conducted in Charlottenburg (migrant and non-migrant research participants alike), and in one interview with a German household in Marzahn. On the one hand, such a distribution of a theme across interviews is a reflection of neighbourhood infrastructures and compositional statuses. As discussed in Chapter 3, Charlottenburg is a neighbourhood with a significantly higher per capita income than Marzahn, which makes a very strong predictor for differences in bio-consumerism. Charlottenburg has many bio-shops, from large supermarkets to smaller deli dealers, and also hosts several weekly farmers' markets. In contrast, I have not located a single bio-shop in Marzahn, and the only interview mentioning bio-consumerism conducted in this neighbourhood contained a lot of complaints about the lack of adequate bio-shopping (the Maiers).

The person in Charlottenburg who did not mention bio was Eva. Perhaps this absence results, on the one hand, from her age (all the other research participants in the neighbourhood were significantly younger), or from the fact that the interview was quite short and mostly focused on medical help.

For all German households, as well as a 'mixed' household (Oleg and Lisa) interviewed in Charlottenburg, shopping for 'bio' was a daily practice of varying importance: whereas Oleg and Lisa, Monica and Holger, as well as Nicole and Eric claimed to shop almost exclusively for bio, Stephanie practised it less. In purely migrant households shopping for bio was also practised, but in a very different way and with a very different conceptualisation, as I will discuss further.

Existing marketing research suggests that preference for organic food is characteristic of a German social stratum referred to in public discourse as *Bildungsbourgeoisie*, the educated upper middle-class. Faltins (2010: 50) demonstrates that education and income are the strongest predictors for organic food preferences in Germany, with size of the household, gender or age playing less decisive role in food choices. Bio-consumerism is a practice, embedded in the general context of social, political and environmental engagement typical of educated Germans. It accompanies voluntary work in third world countries or in environmentally endangered zones and a strong preference for the Green Party, issues which are discussed in the interviews along with health and nutrition topics. These persons see individual health both as a realm of personal effort and as a part of the natural environment; and because to be healthy one needs to think of the environment, consuming bio-products is an act of socio-political participation, not just a private matter. Similar findings were obtained by Baker, Thompson, Engelken and Huntley (2004), who found that preference for organic food in Germany was directly related to environmental awareness. Indeed, native German interviewees stress the individual benefit they gain from eating bio, however, the importance of collective action 'to save nature' is given the same weight or even prioritised in their accounts.

Monica:

We think it is very important to know where the products come from, how they were produced, etc. (Why is that important to you?) Well, because we want to make sure there have been no chemicals used, and that the environment was not threatened by other interests. Massive production of food is a very dangerous business. So, we will rather pay a bit more, but buy from small farms which grow their own stuff and sell it locally. And besides, it just tastes much better! Take tomatoes from a supermarket, and from a bio shop, those are two different kinds of vegetable! It is the smell, the structure what makes a difference. You just enjoy this food a lot more.

Lisa, while inviting me to eat fish with her family tells me I am 'lucky' because usually they 'cook fish rarely'.

The thing is, we only buy bio meat or fish, and it's quite expensive, so we do it only once in a while. Fish is especially pricey, but it tastes so much better! (Why do you do it if it is expensive?) We want to know what we are paying money for. You know what conditions the animals are kept in normally? It's appalling! And the over-fishing is also a really bad thing. The normal supermarket meat comes

from an animal who spent their life suffering, and they die after being stuffed with hormones. First, we do not want to support that kind of economy, and second, it is just unhealthy, because you consume all the chemicals and all the fear hormones that this animal had in its flesh when it was slaughtered.

Holger:

We are a kind of people who like enjoying life. I think health comes from an overall feeling of satisfaction with life. So, it is important for us that we take pleasure in food [essen genießen]. And that also includes thinking of what we eat, because I do not enjoy eating a vegetable which tastes like plastic, or chew on a piece of meat while thinking about a horrible death that animal must have died. So, we try to be responsible.

One of the purposes of these interview accounts is to present a positive public image of the research participant and her family members. Given that environmental awareness is a crucial component of good citizenship for educated Germans, they are likely to create an ethical narrative about nutrition. Holger's remark about enjoying the food, and others' comments about the better taste of bio-food, however, must also be taken into consideration. Altogether, the strategy that bio-eating Germans are adopting is based on the idea of live and let live or *enjoy responsibly*.

Enjoying responsibly implied various aspects to 'local' German interview participants and their family members. First, they suggest eating much less meat. The reasons for either vegetarianism (like in the case of Marlene or Eric) or a marked reduction in meat intake (like in Oleg and Lisa's house) are a combination of ethical, economical and medicalised reasons. Interview participants express discontent with contemporary methods of meat production and call it 'unethical' and 'unfair'. They suggest that buying 'fair trade' meat of bio-quality is very expensive, and therefore cannot be done on a daily basis. At the same time, Monica, for example, argues that these prices are fair in comparison to what she calls artificially lowered supermarket prices. Besides those reasons based on the idea of fairness, they believe that eating too much animal protein is destructive to human health, and it is better to eat as little of it as possible.

Second, bio-consumerism requires the constant collection of information and evaluation of the quality of products. In that respect, German interview participants distinguish between different brands of 'bio', whereby some are referred to as 'authentic', and some as 'spoof'. In order to make decisions, these persons consult a great amount of

resources, from EU regulations of bio branding to recommendations of the German Foundation for Product Testing (*Stiftung Warentest*). They develop complex strategies of navigating the world of bio-consumerism, preferring some shops and brands to the others, whereas the bio brands of chain supermarkets are estimated by them as the least authentic.

Marlene:

All you get in Marzahn is a bio-shelf in Kaiser's [a supermarket chain], and, excuse me, that is, like, ages away from what bio really is. It is just a nice sticker, but it is the same mass produce stuff.

Third, eating bio ideally involves growing one's own: Stephan and Marlene maintain a garden plot, Monica and Holger as well as Oleg and Lisa have a country house with a garden, and Stephanie regrets not being able to plant her own fruit and vegetables, as her family did in the GDR.

In migrant households eating bio acquires very different meanings. Bio shopping is a purely consumerist practice employed, on a practical level, strictly for improving one's individual health, and, on a social level, to maintain identity boundaries and signify social mobility. A fragment from an interview with Natasha illustrates the ambition to be 'not like others', not like 'Soviet/Russian' people migrants strongly associated with bio-consumerism:

N: You will never meet our people in a bio-shop. They are ignorant. They just do not understand, I think.

P: Where do they go, then?

N, laughing: Across the road, to a supermarket. I peek in the baskets sometimes, you know, out of pure interest: kolbasa [sausage] in all sorts, that is it. No bio-food.

P: Germans in your neighbourhood are different?

N: Yes, of course! Germans are a lot more civilized. It is understandable, they are very rich, it is a generation thing. They inherit the capital, it is not like every new generation has to start from point zero, like with us. So, they are a lot more used to taking care of themselves. Before buying something in the shop, they will think twice, do I really need it? Will it do me good? It will take us ages to learn it.

Natasha is attributing preference for *kolbasa* to a Soviet lifestyle. Given that this term has a derogatory meaning (as discussed in section 5.1), she, in fact, stigmatizes the 'others' as both greedy for material pleasures and passive, at the same time. Shopping for bio is almost literally opposed to shopping for *kolbasa* (it occurs 'on the other side of the street'). For Misha shopping for bio is also a sign of a 'responsible' way of taking care of one's health, a way of westernized, non-Soviet or even anti-Soviet behaviour.

If you are a clever person, you will think what you eat, you will keep yourself informed, you will not buy just anything from a supermarket. One shouldn't behave like a hungry Soviet man. It is enough to read the info on food packages to get a heart attack. I go to a supermarket and read: a chemical this, a chemical that. Thanks, I say, I will shop in a bio-market. But our people, they just do not get it. They would eat any trash you give them because it is packed nicely.

In fact, belief that ignorance of 'bio' and 'uncivilised' socialist eating habits are strongly related was also very strongly expressed by the Maiers, a formerly West German couple occupying a private house in Marzahn.

Stephan says:

People here have not departed from their socialist habits yet. It is very retarded here. They do not understand the benefits of bio, what responsible consumerism is. They neither care for themselves, nor for nature.

What makes bio-consuming migrants very different to the Maiers, and, indeed, all other Germans interviewed, is the almost complete absence of environmental or socio-political agenda in their accounts: in strong contrast to native Germans, migrants do not mention any ambition to 'improve the world' in relation to food shopping. Similar findings were obtained in marketing research, comparing motivation for organic food preferences in British and German consumers (Baker et al 2004). Unlike the Brits, who mostly conceptualised the individual health effects of organic food, Germans stressed the environmental aspect of their consumerist choices:

Although similarities emerged with respect to values concerned with health, wellbeing and the enjoyment of life, product attributes sought in order to achieve these values were different between the groups. A major difference was

found in the absence among the UK group of any connection between organic food and the environment. (Baker et al 2004: 995)

Migrants from the former USSR, however, differ from Germans and Brits alike, inasmuch they demonstrate low level of trust in bio-brands and scepticism about their 'healthiness'. On the one hand, as I have demonstrated above, native Germans also feel that not all bio brands are equally 'bio' and healthy, and often scrutinise them carefully to buy the 'best'. On the other hand, migrants have not spoken of any comparable selection strategy: instead, with a degree of self-humour, they continued shopping and hoping, in spite of scepticism, that they were still 'doing the right thing'. For example, an interview with Paul demonstrates the internal conflict migrants feel when investing into expensive bio-products, hoping they are 'healthier':

Paul: Look, I am in a grocery business myself. I know that the whole bio business is nonsense. It is a big cheat.

P: Really? Tell me!

Paul: Well, a company buys a piece of forest and plants something there, according to a bio license. And maybe they maintain a tenth of the plot in accordance to bio requirements, but otherwise it is just the same as anywhere else. No one will really maintain a fully bio farm, it is madly expensive. And besides, just think of it, the ground waters, the air, the rains, how do you control that?

P: So, you never shop for bio?

Paul: Me? No! I don't. My wife does, she believes in this stuff, OK, I cannot forbid her. She is obsessed with all these taste regulators, chemicals, blah-blah. And I mean, ok, maybe she is right. We cannot know in the end. And if I shop for children, I do buy bio, as well. God knows, you don't really believe in that, but still, you want to do the best.

A very similar situation has been reflected upon in Julia and Joseph's family:

Joseph: I think the whole bio thing is just a spoof, just to make money. It is all poured from the same bucket, and then some different stickers are attached. It is all done to make you pay more.

P: So, you do not shop for bio?

Julia: I do!

Joseph: Yes, the wife does. She believes in this nonsense, well, I cannot stop

her.

P: Why do you prefer bio?

Julia: Because with these brands you can at least hope there will be less chemicals, they will be fresh. And I just see where rich Germans go. I can't shop like them, all bio, including meat, but at least some vegetables. They are not enemies to themselves, right? If they buy there it does them good, so, it will do us good, too!

Julia mimics 'rich' German practices, because she believes they are healthier than the ones she knows from her sending country. She feels the pressure to be like a German woman in order to maintain a healthy life. In fact, unlike persons in Marzahn, Julia is empowered in her behaviour by the existence of a local infrastructure: she knows about bio-shops because there are a few in her own street. The Maiers, in contrast, bring their bio groceries to Marzahn from other parts of Berlin and from suburban weekly markets. Marina and Galina, two Marzahn-based Russian German women strongly believing in westernization of one's behaviour as 'healthy' have no comparable example to follow: their 'German' neighbours also go to a local discounter around the corner.

The only 'local' German of persons interviewed in Charlottenburg, who expressed a mixture of scepticism and hope, comparable to the one in migrants' accounts, was Stephanie, who was heavily pregnant when she was interviewed:

I am not sure whether bio really makes such a big difference. I think a lot of it is just money. In the end effect, the air and the rain is the same everywhere. But of course, when the baby comes I will try to buy bio, I think. Just because it is at least some guarantee you are not feeding it chemicals. But I will never become this all-round bio person. It is too expensive and really unnecessary.

Several conclusions can be drawn from these accounts.

First, the distrust towards bio, accompanied by full or partial refusal to participate in shopping practices, is expressed particularly strongly in migrant men: whereas their wives shop for bio, they shrug shoulders and mock them for 'wasting money'. This is in contrast to native German households, where men seem to be equally as involved (or un-involved) in bio-consumerism as their partners. A strong gender division in bio-related health beliefs is only observed in migrant households. This, perhaps, may be explained by an overall stronger expressed role of a woman as the manager of health-related choices: as I will further argue in the next Chapter, most of the informal practices of help within the

household are managed and maintained by middle-aged women, that is, the 'mother' generation. Not only are women expected to perform the role of care-givers, they are also attributed 'natural' knowledge about health. In migrant multiple-person households women perform most of the cooking and shopping for food, whereas in 'local' German households these tasks may be shared between spouses. Hence, migrant women are more aware of qualities of foodstuffs than migrant men.

Second, migrants much more strongly reflect the class meaning of this practice than Germans: bio is a kind of conspicuous consumption which marks migrants who engage in it as 'Westernised' and better off. This strong reflection is likely to result from overall identity boundaries observed in migrant communities. Struggling to distinguish themselves from the 'others', migrants refer to eating 'bio' as a manifestation of their willingness to adhere to the values of the receiving society and to their better-than-one-may-think material well-being.

Third, and, perhaps most important, is the fact that the quality of bio products is regarded as imposed on one, and as with the perception that the natural environment is outside of one's individual control, strongly determines migrants' beliefs about the actual health value of these products. Shopping for bio is not accompanied by active investigation of different brands, like among Germans. Instead, the possibility of 'spoof' is seen as almost inevitable, something one cannot do much about. As Natasha puts it:

Well, Misha, you know, he is really obsessed with all that stuff, he knows everything, he brings food packages to work and tells us to buy this or to buy that. He really believes in that and he knows how to choose. He is my main source of information. But myself, I don't really go into that. I don't really think bio makes such a major difference. I always buy bio-milk, though, because it is the only one I do not get stomach ache from. And some other products, like honey, because it tastes much better. But otherwise, I think it is all the same stuff, with a different sticker, to make you pay more. No one can affect the air and the rain which falls on the fields.

The overall natural environment which surrounds 'bio' farms determines the real quality of the 'bio' food and no one can control the elements. One's ability to affect the quality of nutrition of bio good is thus not unlimited, migrants suggest. We can do our best to choose what the most civilised, the most refined persons choose, but we are not sure whether this will have any direct effect on our health. Interestingly, the only 'local' German person who expressed a similar opinion was Stephanie, a young woman who had spent half of her life in the GDR. Perhaps, the recognition of limitations in bio-produce stems

from being all-too familiar with the pervasive and incontrollable environmental pollution in former socialist countries.

And last, but not least, unlike German interview participants, none of the migrants who shop for bio mentioned growing their own, neither in the sending, nor in the receiving country. Indeed, as mentioned above, the group of migrants comparable to native Germans in that respect are former rural Russian Germans. For them, growing one's own is the best thing one can do for one's health. They have never heard of bio. Instead, they do what *their* gradmothers did: they adhere to tradition.

Summary

The discussion in this Chapter suggests that the degree of disempowerment experienced in the sending country, as well as the migratory process one has taken part in, have a strong effect on ways different persons conceptualise effects of migration on their health.

Previously disadvantaged and some fragmentarily empowered persons continue attributing changes in their health to external factors. Such 'simple' things as reliable housing, safety of public spaces and accessibility of public transport are reflected upon with great admiration, gratitude and are considered to be strong determinants of better health. For many formerly disempowered persons migration meant the alleviation of the daily burden. At the same time, the need to adapt to the rules of the new society is regarded as a threat to tradition and a possible reason for bad health.

The formerly privileged reflect on the new opportunities for taking individual action as the main determinants of their health. They feel that life in Germany enables them to behave as *kul'turnie ludi* and pursue more control over their health by being able to make 'responsible' choices.

The greatest proportion of *indisputably* positive change resulting from migration is attributed to the improvement of 'how life is', in particular, of aspects that migrants consider to be beyond their control: environment and housing. Spheres of life which pressure one to make individual choices, such as nutrition or search for medical help, receive contradictory opinions, depending on whether people feel able to control them. Some aspects of transition are regarded as threats to health, especially those which go against the grain of Russian German identity: unemployment and the collapse of family ties.

Some important exceptions must be mentioned: persons with higher education, but formerly disadvantaged by regional inequalities, tend to conceptualise change in individual behaviour as more important than other migrants with a similar background. For example, of all rural Russian Germans only Marina, Petr and Ludmila believed that German nutrition was not only more sufficient in quantity, but also better in quality. In their family, some practices of westernization are gradually adopted or considered good for health. Education, thus, confirms itself as a strong predictor of one's capacity to change individual behaviour.

The analysis in this Chapter had also demonstrated that in relation to health, nutrition is discussed as a primary realm of individual behaviour. Adaptation to new food

discourses makes up a central topic in accounts of difference between life ,here' and ,there', whereby adherence to particular nutritional practices encodes identity boundaries between communities and generation of migrants. ,Bio'-consumerism of the self-funded, and the produce of own vegetables in upper-class Germans and lower-class Aussiedler can be regarded as participation in ,alternative' food networks (Holloway and Kneafsey 2004). Whereas ,German-German' interview participants associate these practices with the pursuit to establish a transparent and democratic society, migrants place them in a context of individual well-being. However, even though ,alternative' food practices receive different interpretations in respondents' accounts, they are similar in their purpose, which is, according to Holloway and Kneafsey (Holloway and Kneafsey 2004), establish connectedness in a world of endless choice, and to place food in the context of informal care. Care and choice: these two concepts will be central to the next two chapters discussing help-seeking practices.

Chapter 7. Juggling the Choice: Seeking Help from Outpatient Services

When discussing the effects of migration on health, medical care would often be named by migrants as a major health determinant, alongside natural environment, housing and nutrition. In some interviews, however, it would be given greater priority. For example, Julia names German medical care as the strongest pull factor for migration, along with the education system. Having informed herself about healthcare systems in other countries, open to her as a member of the Jewish ethnic minority, she chose Germany for its 'high-tech and accessible' system. Larissa and Mikhail also prioritize medical care above other factors: in fact, the family left for Germany because Mikhail was in urgent need of treatment with which the impoverished Ukrainian healthcare system could not provide him. Both families pro-actively sought help prior to migration (as members of privileged and fragmentarily empowered groups), and place great importance on healthcare. Ludmila, who has been partially disabled for the last few years of her life, speaks little of the healthcare system, attributing most of her well-being to improved housing and to the support of her family. Being severely disadvantaged by regional inequalities, she was unable to seek even the most basic medical help before, and does not prioritize its importance for health.

The healthcare narrative is highly complex, whereby migrants differentiate between the kinds of services they receive in terms of their satisfaction with them, their accessibility and efficacy. First and foremost, in migrants' accounts of seeking medical help, the German medical system is characterised as inherently 'Western' and is opposed to 'Socialist' principles of care provision. The concrete differences concern two major characteristics: technological standards (availability of equipment) and degree of autonomy (structure of doctor-patient relationships). The discussion of these differences oscillates between two major concepts: care and choice. Migrants' accounts of the help that they seek and receive from the German medical system reflects their experience of care and choice (Mol 2008).

Once technological progress and autonomy enable *care*, they are conceptualised as manifestations of Western humanism that the majority of persons are willing to embrace.

Ludmila:

Here you can see that they care, it is everywhere. Simple things, but everything

with a thought about a person. All these wheelchair ramps they build, all the elevators. This is social security. And it cannot be compared to Russia, this is like comparing Earth and Heaven.

Ludmila continues her comparison of German 'care' and Russian 'lack of care' by telling a story of her disabled relative who was unable to leave his house in Ukraine for several years, due to the lack of a wheelchair and most basic facilities. He had to spend the last few years of his life indoors, unable to carry out even the simplest activities independently. In contrast, Ludmila suggests, German technological progress assists disabled and older people to maintain their functional capacities and live a relatively autonomous life. By comparing the life of her parents in rural Russia, who 'sometimes cannot walk out of the house because of the state of the roads' and the life of her mother-in-law, who, having moved to Germany 'believes she was taken to Heaven alive', Ludmila concludes that better housing, available public transportation and hi-tech medicine contribute to one's ability to live longer independently.

The logic of care, as Mol suggests, assumes the perpetual management of roles and reciprocal relationships between persons. Besides, it accepts the simultaneous coexistence of different experts who make common decisions. Care does not oppose tradition; it can be embedded in it. As I will discuss further, migrants mostly attribute 'care' to the two components of German healthcare: inpatient hospital services, the system of resort treatment, and *Pflege* (ambulant nursing care). These aspects of medicine are coherent, on the one hand, with traditional ways of providing informal help, and, on the other, with a traditional understanding of the doctor-patient relationship. Their utilisation causes greatest satisfaction among all groups of interview participants.

However, once technological progress and the ethics of autonomy impose *choice* and a loose structure of doctor-patient relationships, they are strongly criticized.

Emma:

German doctors, all right, they are friendly, sie sind freundlich. But I care nothing about his friendliness, diese freundlichkeit, I want a doctor who takes me personally, who will control me. Like, in our car depot where I worked, we had a surgery, and the doctor there he could be rude sometimes, right, but he cared! Like, he would come to me and tell me, Emma, you are nuts, why did you not show up for the next check-up, I need to see whether your back is getting better, come to my office immediately! So, I could see he cared, he was engaged. And here it is all just blah-blah. You are on your own.

The logic of choice, in contrast to the logic of care, assumes highly individualized

behaviour taken out of the context of tradition and community. Within the framework of the German healthcare system it mostly manifests itself with respect to outpatient services, whereby patients are supposed to act as lay experts, unlike in the USSR where the doctor-patient relationship was characterised by the dominant role of a medical professional.

Migrants themselves distinguish clearly between outpatient and inpatient services, attributing care to inpatient treatment episodes, and criticizing the lack of choice in the outpatient setting. Emma says:

In Germany they will not help you live, but they would not let you die. When you just need help for some mild condition, you are left on your own. But if you have an acute situation and you are brought into the hospital, it is impeccable. They do everything they can. They will fight for your life till the end, and will raise you from the grave.

The shift of responsibility in decision-making experienced by migrants in the outpatient setting is a difficult process. In particular it concerns those migrants who come from a fragmentarily empowered background and who, as discussed in Chapter 4, attribute great importance to being *controlled* in medical treatment. For others, in contrast, the ability to make choices provides a status marker or simply empowers in gaining access to help. The following section of this Chapter will be dedicated to these issues.

7.1 Reflecting on ethics and the logic of choice

Having been socialised in a country with highly centralized healthcare provision, migrants from the former USSR feel pressured to adjust themselves to the individualistic principles of German medical care. The now defunct Soviet healthcare system is often criticized by Western researchers as being de-personalizing, based on command and strict hierarchical relationships between all actors involved in the care-giving process (Field 1957, 1987, 1988; Knaus 1982, Cockerham 1997, 1999; Schechter 1997). Choice with respect to medical care was, as I have demonstrated in Chapter 4, available to only selected groups of the population, and was practised *privately, unofficially and without institutional brokerage*. In fact, choice as enabled by *blat* (informal networks) was only practised in one specific context: in the ability to exercise judgment about when and how it is appropriate to consult a doctor, and which practitioner to choose. Once the consultation was be under way, patients would expect to be subjected to the doctor's opinion and interpretations about the meaning and significance of the illness, in accordance with a paternalistic doctor-patient relationship (Bloor and Horobin 1975). Whereas such a model has been greatly challenged in the West, it continued to exist in the former USSR. Choices concerning the treatment itself would, instead, be considered the responsibility of a caregiver, with shifts towards the patient conceptualised as illegitimate. Altogether, the choice of medical professional or a medical facility was practised to ensure closer supervision. In the institutional context, the role of the medical expert was unquestioned: once legitimized as a caregiver by being drawn into a personalized relationship, he or she would be vested with the power to make choices on the patient's behalf. Personal trust would thus substitute for the lack of trust in the state institutions and private capital would cover gaps in the centralized financing of healthcare; the roles of doctor and patient, however, remained unchallenged at their core. When talking about the effects of *blat* on the quality of care, my interview participants mention that medical professionals would 'check on them better': nurses would pass by their ward more often, doctors would make phone calls to enquire about their condition, more investigations would be carried out to diagnose and more treatments would be offered in the end (cf Rivkin-Fish 2005).

In the modern German healthcare system in which migrants find themselves patients are considered to be private citizens and are expected to choose and consult medical professionals independently. The actual provision of outpatient care in the former FRG, and in contemporary Germany, is mostly performed by solo practitioners. As a rule, in case of illness one needs to consult his or her *Hausarzt* (GP) and receive a referral to a

specialist or a hospital; however, once the referral is obtained, it is up to the patient to decide which practitioner or which hospital she needs to consult. In comparison to a rationed socialist distribution of resources, Germany offers a healthcare market of abundant opportunities. Choice is an institutionalized practice, *empowered by brokerage* of insurance companies and patient organisations. Choice is *public* and *official* and is considered to be a responsibility of the patient, with the caregiver, ideally, exercising only limited expert power.

7.2 Drowning persons should rescue themselves by their own means

Emma, an energetic elderly Russian German woman from Marzahn likes everything about Germany, except its medical care. In fact, she seems to hate it:

German doctors are just a nuisance! I will tell you something. You can say anything you want about the USSR, but in our country doctors cared about their patients, and they controlled them! And here no one gives a damn about you. It is like drowning persons should rescue themselves by their own means (Emma uses an ironic idiomatic expression, "спасение утопающих дело рук самих утопающих"). It was much better in Russia!

Emma explains further:

Here you come to the doctor, and he just stares in his computer. They shake hands with you when you come in, but that is it. No one really cares about you. I think, they have no idea about the human body, they are thinking in very narrow terms. Our doctors used their heads a lot more.

Similar opinions regarding the lack of care in German health care continuously appeared in further conversations with other migrants, with different interview participants unknowingly repeating each other's words. Inna, a Jewish, Charlottenburg-based middle-age woman holds a similar opinion:

I think German medical care is very impersonal. You are being made to decide all the time, like, no one really tells you what to do. They suggest you, may be you can take this medicine. Or may be that. Or may be a surgery. But it is you who decides! I think it is not correct, they have the education to treat you, they should take responsibility. How can I decide if I have no medical education?

These migrants indicate that they value guidance more than they want choice.

Interviews with experts, that is doctors who treat patients from the former USSR, some of them German (mostly former GDR), some migrants themselves confirmed these migrants' views. Hartmut, a GP and an oculist who is German and speaks fluent Russian after finishing medical school in Moscow, says:

I used to be softer with them. Now I just command. I told them, you need a 'direktor' [a boss]. I tell them, you MUST come, and if you don't, we will quit the

treatment and I will inform your insurance company. Then they start co-operating.

Victor, a psychiatrist, who defended his dissertation on issues in the psychological treatment of Russian German immigrants:

You cannot treat Russians like Germans, I am telling you, I had a patient here who decided she wanted to try it with a German shrink, and after two months she committed suicide. Yes, that's true. German psychiatry is too intellectual, it demands too much of a patient. What a Russian need, is advice, a strong figure, a spiritual leader. Someone who tells them what to do, not someone who asks questions all the time and shifts the responsibility to them.

The experts suggest that Russians cannot make choices: they need authority.

These generalizations, although tempting in their simplicity, and easily fitting in the existing discussion of 'passive' Homo Sovieticus, are not quite correct. In fact, persons who criticize the German healthcare system for its choice principle mostly have one distinct characteristic: all of them are institutionally-funded migrants, belonging to a group of formerly fragmentarily empowered and privileged urban population. Julia and Jospheh are the couple making an exception from this rule: identifying themselves as 'westernized', they also embrace the liberal principles of healthcare provision. That is, as the discussion in Chapter 4 suggests, in spite of certain limitations imposed on the Soviet people by the inefficiency of the country's economy, many of them were trying to make choices. Perhaps even, one could suggest, the most empowered of them should have learnt the basic principles of 'doctor shopping' by exercising '*blat*'. However, choices made within the framework of the (post) Soviet healthcare system and choices made in contemporary Germany are different in their organisational and ethical principles, as I have discussed above. Individual care providers, chosen by patients against institutional odds, would often be opposed to the 'system': research conducted at different times and by different persons demonstrates that Soviet people often believed that whereas 'people' (individual doctors) were good, the 'system' was lacking coherence and accessibility (Field 1957, 1987; Rivkin-Fish 2005). A few research participants I spoke to, in particularly those from better empowered backgrounds, formerly able to rely on *blat* and other informal strategies of receiving medical help, also make similar statements.

Ekaterina:

In Germany they have money and technology. It is very visible. You see it straight away. But I do not think it means their system is better than the one we had. Our system just suffered from a permanent lack of money and equipment, but we had very good doctors, our people were the best.

Inna:

They are rich here, it is true, but their system is rotten. Because money cannot decide everything! Our polyclinics and doctors, they were poor, but you could always find some good soul, a true specialist. Our doctors were better trained and they were more compassionate!

Emma:

No one is going to convince me about German medicine. Soviet doctors were the best! OK, maybe the system was not perfect, we all know that, but we had the best people.

First, migrants feel disempowered in making choices due to the structure of the doctor patient relationship. On the interpersonal level, they believe *reliance on technology* alienates care providers from care receivers. The technological progress, extremely welcome in the contexts of hospital and nursing care (as discussed further), is regarded by persons previously able to maintain *blat* and personalize their treatment process (as discussed in Chapter 4) as a manifestation of alienation in the outpatient setting.

Emma:

Here they just rely on their computers. Like, I walk into his surgery, and he just clicks one button after the other. A few questions, a few more buttons to click, good-bye. No conversation, no hands-on care, nothing. Of course, it is good they have all these gadgets, our doctors had nothing like that, they worked in much poorer conditions. But they were listening! They were interested and they treated you as a person.

Inna:

They do rely on their machinery far too much here. Our doctors, they had less equipment, but they had a very high level of expertise. They could diagnose very complex conditions by doing manual check-ups and asking many questions. They had a profound knowledge of anatomy. And these German doctors only know how to operate their computers and have no knowledge of the human body as a whole- I think they are not interested in their patients at all. You are just a case.

Galina:

The main difference is the technology. Yes, of course, they have their computers here. But our doctors were much better trained, they could put A and B together, and were thinking! They were talking to you, they were trying to find out the reason, not just scan you up and down.

Boris:

I think the main thing I learned from my father [who was a high-ranking dental surgeon in the USSR] is that a dentist must, first and foremost, have good hands. If your hands grow from a wrong place, no technology will save you.

In these accounts technology stands between the doctor and the patient, it separates them as individuals and atomizes them. Lack of direct bodily contact is one of the most significant manifestations of an impossibility to maintain a 'personal' relationship with a care provider in migrants' accounts of treatment episodes: they mention absence of manual examinations as a sign of German doctors' unwillingness to see a patient as an individual. There is a clear link: Doctors don't pay attention to their patients' bodies and do not hear their patients'.

Migrants associate reliance on technology with an extremely high degree of specialization in medical professionals, with doctors unable to see the whole, only focusing on issues in their own narrow area. In contrast, they believe that socialist medicine, with its centralized approach and lesser degree of technological intervention, was more analytical and forced medical professionals to 'think with their own heads'. As a result, many formerly fragmentarily empowered and privileged migrants also seek help from ex-GDR healthcare professionals and migrant doctors, sharing the overriding belief that 'they are better qualified' and that 'they see you as a person'. Galina speaks of seeking help for her daughter, who has persistent neurodermatitis.

I do not know how many doctors we saw here. It was totally useless for a very long time. Because they would not use their heads, like our doctors did. They would just tick off the case in the computer. Neurodermatitis? Very well, take cream such and such. And you do not want to cover your child with layers of hormonal creams, do you? You want to find out the reason, not just get rid of the symptoms for a while. So, finally, we found that GDR doctor. I think he must have been very old. He looked like Santa. And he was the first one who actually spoke to me and asked questions. I must have spent at least half an hour there. And he asked me whether we have ever checked her liver. And that question

was like an insight! Of course! We made examinations, and found out it was the reason. I pray for this old man every day, but he is already retired. Some younger guy took his surgery, and I do not know where else to find such a good doctor.

Emma mentions that she is 'going to check on a surgery in Charlottenburg, where a very good old Jewish doctor is practising'. She believes 'he is properly old style, has some knowledge of anatomy, they say, and thinks a bit, unlike these German doctors'. Migrants in this category are ready to travel across the city in order to see a Russian-speaking or, at least, 'socialist' practitioner.

Former GDR doctors themselves also consider themselves to offer a different style of practice. Annette and Hartmut, two doctors mentioned by several interviewees as 'known' among the 'Russians', similarly to migrants, believe that GDR medicine was more analytical than technical and involved more interaction between doctor and patient. Stephanie, a doctor herself and a daughter of former GDR doctors, agrees with them.

Hartmut:

Now the Wessis [jargon for West Germans] took over the Charite [large University clinic in Berlin], what can I say? They read their American journals, and install some super expensive equipment, but they do not know how to treat real patients! They only know how to do this or that from A to B. The GDR doctors, we were taught to understand the whole anatomy of the human body, to see our patients as a whole. We would think with our heads. And they can only scan and screen.

Stephanie was a patient in Charite herself, and at the moment worked there, as well. She could observe the clinic in transition:

When I was treated there first, there were still a lot of GDR doctors. People my parents used to work with before we fled. They knew each other. But this is not the point. They treated everyone very well, they were more qualified, I think. They had very wholesome knowledge. This, I think, is a result of the education system as a whole. My younger sister, she went to school in the FRG, after we fled. And I think her knowledge is a lot more fragmented than mine. Same about med school. In the FRG they would teach you only what concerns your specialization, and in GDR doctors were better trained to see the body as a whole. So, I think I was treated by better specialists than the ones that work there now.

In spite of agreement about the different quality of qualifications in former socialist and FRG medical professionals, doctors feel that their 'Russian' patients do not fit in with the system of doctor-patient relationship they practise otherwise. With them, they say, they feel pressured to exercise a stronger degree of expert control than with 'German' patients.

Annette:

What they do not understand, is that a successful treatment requires a lot of work on the patients' side. They would not even take their pills on time, and you know, with antibiotics it can be very dangerous. Their illness becomes drug-resistant, and we have to start all over again, sometimes by introducing very expensive drugs, because nothing else works any longer. And if I issue a referral to a different expert, for an extra check-up, they would not go. I must check every step they make to ensure we are getting somewhere.

Hartmut:

There is very little initiative on the patients' side. They want miracles, not mundane treatments. Like, they keep asking me whether I would recommend them to drink urine or do feng shui, or some other crap they read about in the Russian press, but they would not take pills I have prescribed or show up for regular consultations. They just do not care enough! How many times has a typical Russian patient of mine lost a prescription? All the time! They do not understand what it costs! I tell them, they have to do something themselves! Otherwise, I feel like a vet!

These healthcare professionals deal with a particular segment of the migrant population: as I have mentioned above, mostly formerly fragmentarily empowered and privileged persons. For many of them, control exercised by an expert served as a manifestation of care in the sending country; having been socialised under such conditions they continue projecting their expectations onto German doctors. Moreover, general migration-related disempowerment caused by unemployment and loss of established social networks, makes these persons more dependent on the help and expertise of medical professionals than they might have been in their sending countries, where they were able to receive help by means of informal contacts. In the next section of this Chapter I will demonstrate that in contrast to these persons, other migrants (with formerly disadvantaged and privileged backgrounds), in fact, rely on the help of German-speaking

'local' doctors and feel very satisfied with the care they receive. A few persons mentioning Annette and Hartmut as 'famous' doctors were satisfied with their 'old school' approach. Others, on the contrary, felt they were 'Soviet'. Instead, they were ready to embrace the new world of healthcare and the new kind of practitioners: some out of gratitude and some because of a desire to westernize themselves.

Migrants confront the core *organisational principle* of German healthcare as unethical: that is, paid insurance. Formerly better empowered persons believe that doctors' incomes should not be directly dependent on the number and complexity of cases he or she is treating. Pecuniary interests, they suggest, should not arise between care providers and receivers, and doctoring should be governed by moral and ethical principles, with financial issues covered by the state.

Inna, for example, says:

What I do not like here, that doctors make money out of you. It is a business, and nothing but business here. Like any other. Our doctors, they wanted to choose this profession because they had some ideals, they wanted to help others. And here it is just a well-paid occupation.

The insurance principle is regarded as unfair, unequally enabling some people to make choices. Migrants talk of inequalities produced by the parallel existence of different kinds of insurance, with privately insured patients receiving quicker and better care than those insured with statutory funds. Such inequality strongly contradicts the ethical principle of 'free of charge medical care for all' that migrants have internalized in the former USSR. These migrants ask 'If Germany is the land of plenty, why cannot its government make sure that everyone is taken care of? Why should individuals be responsible for their own fate and fight for resources, when there is so much to offer?'

Acute awareness of inequality in the insurance system, with privately insured persons being seen with shorter waiting time and more attention than those public insurance, may cause a feeling of direct stigmatization.

Emma:

I needed an appointment with a dermatologist. All I heard was 'come in two months!'. And I wonder, What should I do in these two months? Die? That is what happens if you have state insurance.

Ekaterina also complains about inequality:

My GP keeps laughing at my questions. She tells me I am too demanding, and that the German healthcare system does not have that much money. I am sure you can have very nice treatment here if you are privately insured, but not otherwise.

Tanja:

I asked my gynaecologist to give me something against stretch marks. I was in terrible pain, my skin was all red. And she gave me a tiny tube of a tester and said, Germany is a poor country. If I were insured privately, I think she would have given me something better.

Migrants argue that in the USSR the failure to provide equally for all resulted from material shortages, in Germany, in contrast, it is a result of immoral principles, of failed ethics. And whereas they felt that in the USSR the individual effort of selected persons could keep the principle of fairness and empathetic care alive, Germany seems to provide them with no space for personalization. Indeed, along with technology, the insurance principle brings yet another impersonal mediation into the doctor-patient relationship. Of course, sufficient funding available to healthcare in abundant Germany means that patients have no need to compensate for shortages from their own private resources, neither in terms of social, nor material capital. However, it also means that persons who previously benefited greatly from informal payments and exchange feel stripped of the most direct way of controlling the course of treatment, and cannot make choices by micro-investments into specific sectors of an otherwise crippled system. For example, Inna says:

This whole insurance principle, I don't get it, honestly. Like, I pay my hundred euros per month for it, but what do I get for it? Nothing! They hardly speak to me. Of course, I am not privately insured, so they don't care. I think in the Ukraine it was much better for me. There I would just go to an acquaintance doctor, bring them something in an envelope and a bottle of wine, and they would treat me like a queen!

Ekaterina, who worked as a nurse herself, while, at the same time, coping with MS, suggests that the insurance principle cannot substitute for personal networks in access to

the most precious resources. Referring to help she was getting informally through a network of medical professionals in Ukraine, she estimates medical care in Germany as poor, in spite of its technological achievements.

Three persons spoke of feeling stigmatized in a doctor-patient interaction, attributing it to being a migrant. Tanja, the only person with a former disempowered background who is very critical of German healthcare, speaks of pregnancy supervision:

And everything this woman [a gynecologist] was telling me, was 'lose weight, you must lose weight'. She would not do any proper examination on me, telling me, she cannot identify the gender of the baby or the size of its head because I was too obese, and, like, my fat would not let her ultrasound see. So, when I was sent to the hospital, I still had no idea of who I was about to give birth to, and how big the baby was. And because she had not properly checked me up, I was screened in the hospital. And they said, nonsense, we can see everything, and in fact, your baby is so huge we have to give you a caesarean. So, thank god, they checked. And I think she treated me like that because I am not German. I mean I am, but for her I am Russian. So she thinks she can treat me like trash.

Tanja's mother and Inna also thought they might be treated by German doctors 'badly' because they were identified as 'Russians'.

Feeling alienated from their care providers by technology, insurance and cultural descent, some patients continue relying on 'Soviet' methods of establishing a personal relationship with medical professionals by offering them small gifts. However, they do not lead to the expected result, rather causing perplexity in all actors. Eva says:

I was very impressed with how polite the nurses were in my oculist's surgery, and the next time I came I gave each a chocolate, they were happy, but a bit shocked, I think!

Stephanie also tells of her experience of treating patients from the former USSR. She points to the fact that 'Russians' have a different pattern of timing in offering presents, and their scale is different:

They are very grateful persons, it is very pleasant, but sometimes can be misleading to us. Like, of course, we doctors like it a lot when patients give us gifts. But a German would bring may be a bottle of wine or a small bouquet of flowers, and only after a surgery, not before! Whereas a Russian brings you a whole box of alcohol, and it is not wine, it is expensive hard liquor. But the most

important thing is, they give it to you before the surgery. So, you feel perplexed, like you owe them something, and our business is really unpredictable, it is sometimes very unpleasant to feel like now you must treat this person by all means.

Difficulties in making choices and disapproval of principles in care provision mostly arise in the out-patient setting, with patients complaining about being given only very vague directions about their treatment process and not being referred to other specialists. As I will demonstrate in further sections of this Chapter, almost all migrants, including the critics of German healthcare, feel great satisfaction with inpatient services and nursing care.

At the same time, two categories of migrants express satisfaction with the choice and insurance principle: the self-funded and the formerly disempowered institutionally funded. The latter demonstrate complex strategies of managing the abundant offer of medical services: the self-funded. For them, the liberalized medical system is the pinnacle of westernization they are willing to embrace. The former seek help in less sophisticated ways, however, they reflect on the great benefit of the local healthcare system for their health. Both groups endorse liberalized healthcare provision as effective and ethical, however, as I will discuss in the next section, for different reasons.

At the same time, two formerly fragmentarily empowered families, Larissa's and Julia's also demonstrated strong satisfaction with the way German healthcare was organized and the quality of care they were receiving, which makes up a part of the ambition of these persons to westernize themselves.

7.3 Endorsing the liberty: Shrugging off the socialist past

Reflecting upon changes in the German healthcare system since re-unification, Paul suggests that 'socialism' has a corrosive effect on the quality of healthcare. He argues that state regulation of insurance, defining the benefit doctors make from treating each patient, is happening at the cost of attention medical professionals can give to their clients.

Similarly to Inna, cited in the previous section, Paul criticizes the 'conveyor belt' principle. However, unlike her, he believes that improving the services can only result from their liberalization, not rationing. Marina, a person with a background strikingly different from Paul's also suggests:

Here they are in a competition. They need to be polite to you, because they fight for every patient. And it is very good! Because in Kazakhstan they can be as rude to you as they wish, and nothing happens, no one will get fired or anything.

Ease of access to services seems to be the most decisive reason for satisfaction with German healthcare services. People with such different, almost contrasting, backgrounds and statuses as, for example, Paul and Marina, talk of healthcare services in Germany being comfortable, predictable and reliable. However, it is likely that their understanding of 'comfort' is different.

For Marina and Petr, Larissa and Mikhail, Julia and Joseph, Ludmila and Eva, comfort means the sheer availability of services inaccessible to them in their own countries. It is a profound change in how life is, reflected upon with gratitude and surprise. For example, Ludmila, Eva, Julia and Joseph are especially impressed with their ability to receive rehabilitation and resort treatment after surgeries.

Ludmila:

This ReHa [rehabilitation medicine] is the best thing which happened to me! I wish I knew about it earlier. Because no one told me of it after my first surgery. But now, when I finally had it, I can see what an effect it has on me. I get very tired there, doing all these exercises and treatment, but it does me heaps of good. Certainly, in Russia nothing like that would be possible.

Eva:

Just think resort treatments. Here anyone can go to a resort once in four years, or after a major illness, and it is all paid by insurance. I myself know a couple

who had been seven times! I met them when having a holiday there myself, all covered. In Russia no one can afford that, only very rich people, not pensioners like myself.

Joseph:

And so, after my heart attack I could go to the Baltic coast. It was all covered by the insurance. I got a bit stitched up there, walked a lot, just took a good rest. One has to have a rest from the family, even such a good one as mine! [his wife laughs] I think it is very generous that the insurance pays for it.

For the formerly disadvantaged, German healthcare, in fact, is an important component of the generous world of plenty and its better life.

For those in the category of formerly privileged, the self-funded migrants, commodity means not having to mobilize all social networks in order to get a service which should otherwise be accessible to everyone. It means freedom from reimbursement of informal exchange, and predictability of service quality, guaranteed not by personal acquaintance, but by institutional structure. Paul, reflecting on his hospital treatment, says:

I had that heart attack once. Well, I will not bore you with details. But I had to go into the hospital. And it just worked perfectly smoothly, everything functioned. Not like you had to make thousands of phone calls before to find a place where they will not slaughter you.

These two different categories of migrants, both highly satisfied with German healthcare, seek help in quite different ways. The formerly disadvantaged, as well as Julia and Larissa, mostly utilize outpatient services available in their vicinity, and do not specifically seek the help of Russian-speaking doctors. In some cases, migrants continuously rely on the help of doctors they started seeing when still living in the transitional camps, but the majority switches to those practitioners who have surgeries closer to their homes. In these families lack of language proficiency is compensated for by participation of the extended or nuclear family in the treatment process: children accompany parents to doctor's appointments. Participation of children is regarded as expected and desirable, both in post-figurative Russian German families (the children fulfil their duties) and in the Jewish family of Julia and Joseph (the children demonstrate their success). Information about practitioners in the neighbourhood mostly comes from other migrants living next door or from institutional sources: referrals of other healthcare

professionals or migrant organisations (Jewish Community and others). These persons do not seem to have a strategy of help-seeking; help is sought sporadically and from the most available sources. At the core of their satisfaction is a perceived difference between the quality of care 'here' in Germany compared with 'there', which means that migrants tend to try to be 'undemanding'.

Ludmila:

It is a sin to complain! Some-one who has not seen the life there, maybe has something to say. But we, we can compare, and I am saying, there is nothing to whine about!

In contrast, self-funded migrants utilize the choice option of the outpatient services to the limit, developing highly sophisticated strategies of locating specialists they believe to be best qualified. In that respect, two practices are specific to this group: avoidance of doctors with a 'socialist' background and reliance on help of certified non-biomedical practitioners. Below I will discuss these practices in more detail.

7.3.1 No Russian doctors, please!

The rejection of 'Soviet' or 'Russian' medicine and eager endorsement of German healthcare means that some migrants avoid the services of migrant doctors. To a great extent, this kind of help-seeking behaviour is an important step in reflexive westernization. This practice is especially expressed in self-funded migrants, who also tend to have a good knowledge of German. However, Larissa and Eva also spoke of seeking help only from 'local' German doctors.

In fact, distrust in the qualifications of 'Russian' doctors is associated in interviews with distrust in the qualities of all Russian services altogether, and a belief that 'German' is by definition better than 'Russian'. In Larissa's words:

I do not deal with any Russian businesses anymore. They cheat on you shamelessly. For example, last time I was in a Russian shop, I bought a bottle of champagne there. You should have heard how they advertised it to me. And when we opened it at home, it turned out to be lemonade. That is it, I said. Nothing Russian anymore. We came to Germany and we will live like Germans.

Sonja also expresses scepticism:

I was in Russia recently and wanted to buy a linen table cloth for a present. It cost a fortune, and it was a cheat! One of my friends told me, she bought the same table cloth before, and it lost colour after the first washing. So, how can you trust anything Russian? How can you buy pills there? They are all spoofed! Drug stores are full of fake medicines. This is how business is done there, and this is how it is done here by Russians, too. I just stay away from it, it is a world of its own.

By claiming not to seek help from 'Russian' doctors, migrants declare their independence and eagerness to westernize themselves as Germans. In the rejection narrative Russian doctors are attributed with poor qualifications and a lust for money.

Natasha says:

Of all the Russian doctors who practise here, only those who came in the 1970s are worth consulting with. They are not Russian; strictly speaking, they are all Jews, very qualified professionals. All these persons from the 1990s, I do not trust them. They came, opened a surgery, all quick and with little experience. I

do not think they are qualified, to be honest, I think they just make money. And who knows where they got their license. But, you know, lately even those old Jewish doctors have become not so good. They are also starting to think only of money.

Sonja reports of an illness episode poorly managed by a 'Russian' doctor:

That was in the beginning of my staying here. I suddenly started feeling drab, was a bit sick all the time, kind of sleepy. It just felt wrong! So, I went to some Russian doctor my acquaintances had recommended to me. They tried to help me in that surgery, I cannot complain. They told me I needed to receive vitamin transfusions, and would have to come for a dropper every day. Because I worked, they would even open the surgery for me out of hours. But it just was not helping. I was coming every day for 10 days, letting them pierce me with a dropper, and I only felt worse. Eventually, I went to a normal hospital, and there they diagnosed severe iron deficit and, finally, treated me properly.

Larissa and Mikhail also tell me of their long medical journey in search of a doctor able to take care of Mikhail's various chronic conditions, of which diabetes is the most pronounced one. At first, Larissa says, the family consulted a migrant therapist, a Russian woman from Kazakhstan. She was recommended by one of the former camp neighbours. Once, Mikhail went to see her feeling unwell. She examined him and said 'he was fine'. Upon walking out of the surgery, Larissa says, he collapsed with a heart attack, and was taken to a hospital where he was 'taken care of properly'. Since then they have changed therapist, and see only 'local' German specialists.

However, there are occasions when migrants turn to the help of 'Russian' doctors but it is stressed that such practitioners were chosen on the basis of his or her outstanding qualifications, and not because of an inability to find a German specialist in the same area. For example, when I asked Boris about the staffing principle for his surgery, he said:

Oh, I did not look for Russians. I placed an ad in a professional magazine, like everyone else does, and it is a co-incidence that a few Russians replied. I only took them because they were good and experienced. Trust me, that is the only thing that matters.

When I asked whether he sees some Russian doctors himself, he said:

I do sometimes, and I sometimes send my patients to them, too. Do not get me wrong, they are very good specialists. Like, this anaesthetist, he was a Doctor of Sciences in Novosibirsk. He is very good, I trust him completely. He is the best for dental surgeries.

Boris is demonstrating independence from the migrant community, stressing that he hired his staff by means of a corporate channel. In fact, his words are a response to an implicit unspoken stigmatization associated with Russian doctors, whom he feels he needs to defend by praising their professional qualities.

Migrants described consulting migrant medical practitioners in the beginning of their stay in Germany. Departure from dependency on their services symbolizes one's gradual westernization and growing identity as different from 'other' migrants. Like 'unhealthy' pizzas eaten upon arrival in the world of plenty, they are being left in the past as other, more refined, more 'cultured' strategies take their place, of which visiting a *Heilpraktiker* is the most indicative.

7.3.2 Reliance on Heilpraktiker

Whereas some persons consult exclusively biomedical practitioners, others also seek help from certified non-biomedical healers, the so-called *Heilpraktiker*.

Heilpraktiker is a highly specific sector of German healthcare, wherein traditional and non-biomedical healers are a part of the statutory healthcare system. Their education is relatively standardized and they undergo a process of certification, necessary to open a consultancy. The variety of care options offered by such practitioners is very wide: from traditional homeopathy to Ayurveda to new age healing methods, such as Reiki.

Heilpraktiker deal with different sorts of issues: whereas some assist at birthing, others consult on managing chronic illnesses. Indeed, they offer a world of care as complex and broad as the biomedical one.

Although *Heilpraktiker* are an official part of the existing healthcare system, their services are only marginally covered by otherwise comprehensive public health insurance: according to German healthcare legislation, persons insured with public funds in most cases need to cover the costs of *Heilpraktiker* consultations from their own pockets (although some exceptions exist). Private insurers may have other policies, depending on their business strategies. The necessity of paying for non-biomedical treatment on top of the existing insurance means that persons with lower incomes, especially those reliant on social welfare, are less likely to utilize such services. Indeed, visiting *Heilpraktiker* is mentioned only by self-funded migrants, that is, persons with the highest socio-economic status as compared to other groups of migrants. Misha claims to seek help from *Heilpraktiker* exclusively, Natasha visits one regularly with her children and Sonja and Boris utilize such services from time to time. Reliance on non-biomedical treatment methods constitutes an important component of *kul'turnost* for these people: critical perception of medical care and the permanent search for alternatives is regarded by them as necessary for a person truly willing to take responsibility for his or her health. By visiting a *Heilpraktiker* these migrants manifest their highly individualized understanding of health and distinguish themselves from others, less aware about their bodies. To understand the intricacies of these beliefs and behaviours, it is worth placing them in a biographical perspective and looking briefly at migrants' experience with non-biomedical medicine in their sending countries (as discussed in Chapter 4).

Persons who rely on the help of *Heilpraktiker* mentioned their families consulting 'quasi-scientific' practitioners prior to migration, or, at least, being familiar with the

principles of 'quasi-scientific' treatment. Formerly these people belonged to the category of privileged, and already in the USSR combined non-biomedical healing with complex strategies of utilisation of biomedical medicine.

Reliance on such healers is partially interpreted in migrants' accounts as dissident political beliefs, because it suggested autonomy from centralized state healthcare and its medicalized ideology. Given that many systems of alternative healing focused on spiritual healing and saw matter as secondary to soul, they also opposed the socialist materialist ideology at its core. Instead, they suggested a highly individualistic approach to each person, something that interviewees believed, was only possible in the West. Thus, similarly to eating salad, consulting a homeopath acquired a political nuance of non-compliance and westernization. Misha speaks of his ex-wife and her mother as persons extremely savvy in terms of non-biomedical treatment:

They took care about their health, very much so. For example, they did separate nutrition [that is, not mixing carbohydrates and proteins in one meal] before everyone else started it. It was impossible to get any books or any information about healthy nutrition in Ukraine, but intelligentsia had their ways, they photocopied it, or even made notes by hand. If you want to know something, you will! In the West that had existed all along, but nothing would be let into the USSR. And then, they did all these breathing exercises, relaxation and detoxification, you know, they would consult the right people or gather information piece by piece. They did everything!

Sonja's family utilized a great variety of biomedical services, mostly by means of personalization through informal networks, and a doctor practising Chinese medicine (in particular, acupuncture) provided help to her parents. Natasha, Sonja's fellow Muscovite mentions seeing a homeopath a few times.

These persons had acquired the skill, the habit and the knowledge of combining biomedical and non-biomedical treatment options in their sending countries. The availability of certified non-biomedical healing through the German healthcare system empowers them to continue seeking help the way they consider most optional: whereas in their home countries they did it against the odds, in Germany their behaviour is endorsed by the ideology and organisation of healthcare provision.

Persons consulting non-biomedical practitioners conceptualise their help-seeking practices in terms of *kul'turnost*: for Misha, for example, it is undeniable that a person taking care of their health sooner or later will depart from the realm of biomedicine, which he believes to be intrusive and impersonal.

Kulturnij chelovek, somebody willing to do something for their health, they must understand the difference! They should read books, think with their own heads and figure out, what it means to swallow all these pills. I only see Heilpraktiker now. The last time I was at the normal doctor was ages ago. I had really bad tonsillitis, and it would not go. So, that guy gave me some horrendous anti-biotic, it was awful, I thought I was already dead! And the worst thing, it would not get better! I went to a Heilpraktiker, and he just gave me some crystal salts, and it was gone!

Misha says he also never sought biomedical help for his son:

Me and my wife, we just made sure we learned something about the human body. And every kulturnij chelovek should understand the effects of biomedicine, how it destroys the natural immune system. With our son, for example, we never tried to reduce his fever. He would burn, like a candle, and be renewed by illness. Our Heilpraktiker explained to us that illness only makes children stronger, and one should not interfere.

Natasha also takes her children to a *Heilpraktiker*, believing that there they get treatment more adequate to their tender age than in the surgery of a biomedical practitioner.

I want to make sure we try everything before going for antibiotics. And with normal doctors it is not the case. It is all very technical, they pay little attention to individual cases. Of course, there are cases when an anti-biotic is necessary. But not for a simple cold, for example.

For Misha and Natasha alike, reliance on *Heilpraktiker* is an explicit departure from the socialist past: they both cast 'soft' non-biomedical methods against 'mass' Soviet medicine and its impersonal treatment of a patient. In Misha's words:

Only these fat, pelmeni-eating Soviet persons take all drugs they can without giving a damn. One must be a bit more responsible than that.

In their reliance on *Heilpraktiker* these self-funded migrants may only be compared to Charlottenburg-based Germans and the Meiers (a family with a private house in Marzahn). Similarly to them, they talk of the destructive effects of antibiotics and intrusive methods of biomedicine. In the Meiers' case, the discussion of non-biomedical medicine acquires the same anti-socialist meaning as in Misha's and Natasha's accounts. They talk

of doctors based in Marzahn and East Berlin as rigid, dull bio-medical practitioners, whose way of dealing with patients is deeply infested by the socialist political system. They cast them against the 'liberal', 'humanitarian' and 'individualistic' *Heilpraktiker* they see in West Berlin. Stephan says:

These people, they still think everyone should get the same kind of treatment no matter what. Because we say so, period. For example, Marlene gave birth to twins in [hospital in West Berlin]. It was a normal birth, but because it was twins they wanted to check them extra with a paediatrician. And this hospital did not have one. So, they have sent us to [a big East Berlin hospital] where the doctor-in-chief gave us a long brainwashing about daring to give birth just like that. With us, he said, you would have been given a caesarean without a minute of consideration. We would make you! Because you must. This is how we do it! And this is how it goes here, this is the mentality. Here in Marzahn all doctors are like this. They would prescribe you antibiotics for anything and command you around.

In the surgeries of *Heilpraktiker*, instead, the Meiers feel respected and cared for as individuals. Marlene says:

I can ask anything I want. And my desire not to hurt myself is respected! They will patiently try a hundred soft methods on you before they find one, but they will not force you!

Altogether, migrants' reliance on certified non-biomedical healing is more of the exception than the rule, performed only by self-funded migrants.

Summary

In this Chapter I have demonstrated that migrants' expectations of medical professionals remain unfulfilled in the outpatient setting, where they are being placed in the structure of a doctor-patient relationship which feels unethical and unfair to them.

On the one hand, the outpatient setting which shifts the responsibility for management of an illness episode or a chronic condition onto the patient contradicts the traditional expectation of the paternalistic doctor-patient relationship many Soviet persons (especially, the fragmentarily empowered) have been socialised with. On the other hand, it also increases the decision-making load of 'lay experts', that is, middle-aged women, who, as I have argued in Chapter 5, are universally perceived to be key health providers to all other family members across all groups of migrants, with all family structures.

The lack of direct links between outpatient services and other healthcare sectors, that is, inpatient and nursing care, creates gaps in treatment covered by means of the informal networks and migrants rely on their families for help. A case providing closer insight into this issue will be discussed in the section of the next Chapter dedicated to nursing care.

In contrast to the outpatient setting, hospital treatment which, in terms of care organisation principles, somewhat reproduces structures at the core of socialised medicine, is perceived as caring and fair. Hospitals are perceived as places where the logic of care, in fact, takes over from the logic of choice. Similarly to the inpatient setting, nursing care is also perceived by many migrants as a great resource of help and support in their everyday lives. The next Chapter will focus on these aspects of help-seeking.

Chapter 8. Following the Tradition. Satisfaction with Care: Hospitalisation and Nursing Care

Whereas ambulant medical care in Germany receives criticism, especially from formerly fragmentarily empowered and privileged institutionally-funded migrants, inpatient care is equally praised by all persons I have spoken to. Of the self-funded migrants interviewed, only one person had an experience of hospitalization in Germany for a reason other than giving birth: Paul, who had a heart attack. Given such lack of material, I will focus on the hospitalization experience of the institutionally-funded migrants, whereby giving birth will be discussed as a separate theme.

Migrants speak of hospitalization as a help seeking strategy applicable only to gravely acute cases: significant worsening of a chronic condition, accidents, heart attacks and the like. Giving birth is also regarded by all migrant women I have spoken to as a hospital case. In this Chapter I will demonstrate that the setting of inpatient care is consistent with the traditional structure of the doctor-patient relationship migrants have been socialised in, and, therefore, fulfils their expectations about adequate care best.

At the same time, against my initial expectations, many elderly migrants, including Russian Germans with extended families, seek help from *Pflege* or institutionalized nursing care providers and report great satisfaction with their services. The scope of *Pflege* services one may claim depends on the *Pflegestufe* (disability degree), which is defined by an independent medical committee, and includes daily household assistance, outpatient and inpatient medical treatment, as well as a range of social benefits (sponsored public transport or access to cultural events). The actual services are provided by *Pflegestationen* ('care stations') organized on a territorial basis, which operate and compete with each other as independent businesses whereby persons must make their own choices about preferring a concrete service. Reliance on ambulant *Pflege*, against my expectations, did not mean threat to the traditional division of labour in the household to interview participants. Instead, it is regarded as an alleviation of the daily burden for everyone, and is endorsed by all family members involved in the caregiving process, especially, women.

The next sections of this Chapter will study hospitalization and *Pflege*-reliance as help-seeking practices.

8. 1 Hospital treatment. Acute Illness Episodes and giving birth

Accounts of hospitalisation across different groups of institutionally-funded migrants are strikingly similar in addressing staffing, efficacy of treatment and comfort of accommodation, as I will discuss further in this section. In accounts of being hospitalised, a trend of emergency hospitalisation is also dominant.

Larissa:

I was in the hospital myself. I had a very strong pain in my stomach one day, so that I could not even walk anymore. It was terrible, so I decided to call the ambulance. They took me to the hospital, and there they cut a benign tumor the size of a grapefruit out of my uterus. It was that big! (Interviewer: Had you known about it before?) I knew I had polyps there, I already knew it in the Ukraine. But because he (her husband - P.A.) is always so ill, I have to take care of him. Have no time for myself. I did not do anything about it, really. So, when the thunder struck, I went to the hospital.

Inna, of her husband's cardiovascular condition:

And so, because his GP would neither moo, nor calve [would give no clear directions] he was just waiting, and waiting, and waiting. His condition grew worse every day, eventually he had difficulties getting up from his bed and going to the loo but no, he said, the doctor did not say I must have surgery, so I wait a bit. So, we called an ambulance when he was already half-dead, almost unconscious already.

Experts observe similar patterns of hospitalisation in migrants, as well. Andrei, a surgeon in a large hospital on the rim of Marzahn, says:

Our people come much later than Germans. I mean, they may have the same condition, but it is always a lot more expressed. The symptoms are more developed, they have stronger pains. They seem to wait till the last moment.

Jonas, an ambulance assistant in Marzahn, daily bringing ill persons to the hospital where Andrei works, expresses the same opinion:

Russians wait till the last minute. They call the ambulance when they really cannot endure it anymore, and given that they seem to be more enduring altogether, it is really, really late. Sometimes I wonder how on earth I am going to transport this person at all.

Cases of less urgent hospitalisation occur when a referral to a specific clinic was issued and acceptance was arranged by medical professionals from who migrants receive primary care. That is, in cases when migrants would be spared the choice of clinic (which is open to them in case of planned interventions) and bureaucratic hurdles.

Ekaterina and Kirill tell of the efficient communication between Kirill's GP and the hospital:

E: He called that clinic in Y right away, right?

K: Yes, he did. You see, I had pain in my chest, and I went to my GP to check on the heart. And he said he did not like something about it, so he suggested I go to a clinic in Y (a famous hospital, formerly catering to the GDR party elite - P.A.) and have it properly examined or may be even operated. He said straight away that surgery is very likely and I must be ready for it. And then he called that clinic and arranged that I see a particular professor there.

E: So, we knew where to go. We had a referral, and we had the name, and we knew what to expect.

K: Yes, it was like clockwork.

A very similar episode was reported by Julia and Joseph, also with regard to a heart attack. In Julia's words:

We have a very good GP, we are very satisfied with him. And he helped Joseph very much, when he had that heart attack. I mean, he did everything for him to get into a good hospital. (Interviewer: How did you choose a hospital?). We did not choose a hospital ourselves, he told us straight away we had to go to X and get examined. He also said, Joseph was in urgent need of by-pass surgery, and gave us a referral. So, we were well prepared and knew what to do. It went very quickly, he was taken very good care of. And when he was back home, the GP issued him a referral for a post-operative resort treatment!

Persons cited above feel that seeking hospital treatment can only be legitimated either by the nature of one's condition, or by judgment and assistance of a medical expert. In the former case one is left with no choice, in the latter the choice is being made by someone else, vested with the power to do so. The 'endurance' or 'reluctance' to seek hospital treatment may be explained, on the one hand, by understandable fear of highly intrusive methods practised there, and one's desire to avoid or postpone them for as long as possible. On the other hand, it may also be explained by migrants' previous experience in their sending countries, where, until the collapse of the USSR, a strong link between

inpatient and outpatient services was practised, with polyclinic GPs issuing referrals to hospitals and, ideally, informing the practitioners there about the patients' cases. Due to the highly fragmented nature of the German healthcare system and the shift of responsibility towards the patient, this link is often missing, persons not even being aware of choices they are supposed to make (like in the case of Inna's husband). However, when the traditional doctor-patient roles are in place, with experts making most of the decisions and giving clear imperatives to the patients, the help-seeking process becomes much smoother ('like clockwork'). 'endurance' may result from functional health beliefs and the virtue of 'not complaining' acquired by some migrants (mostly, the formerly disempowered) in their sending countries. Petr's words illustrate the virtue of 'endurance':

I had a loose tooth once, and I went to the dentist. And he tells me, now, let's give you a pain killer first. And I am, like, braucht man nicht (no need). So he just gives me that weird look. And I am laughing, come one, man, just pull it out. I think he was sick of this idea himself! I was used to a different life, you know. There I would pull my own tooth myself, not to waste time. Because in the dental clinic they would not have instruments and pain killers anyways, too. And I had work and household to take care of. I am telling him, no need to give me a pain killer, I can tolerate the pain. And he is, like, but why tolerate it! We can make it painless!

Whether one was hospitalised 'half alive', like Tamara's husband, or for a planned intervention, like Kirill and Joseph, the satisfaction with the treatment received there is equally high. On the one hand, German hospitals embody the achievements of technical progress and convenience, otherwise characteristic of the 'world of plenty'. They contrast with the impoverished and poorly equipped Soviet hospitals, where the treatment was often perceived as 'crippling' rather than 'curing' (Rusinova and Brown 2002). Accommodation arrangements alone give a sense of great satisfaction.

Eva says:

I am very, very satisfied with the hospital. First, I was only with one person in a ward. Then, it was very clean everywhere. And the bathroom was right in the room, not at the end of a long corridor, like in a Soviet hospital. I could even take a shower!

Such comforts cannot be taken for granted in many post-Soviet hospitals, where people need to share a ward with five or six other persons, and hygiene facilities are in a

very poor state. Other persons speak of the availability of clean bed sheets in the hospital, hot meals, elevators and tidiness as highly impressive. Previous experience had prepared migrants for a different standard, even those who were more privileged than the others.

Unlike in the outpatient setting, where some migrants are willing to be treated 'analytically' by means of body contact, manual examinations and conversation, in the hospitals heavy reliance on equipment and computer-assisted diagnoses are regarded as desirable and necessary.

Julia:

Of course, they could do this surgery easily, they have such wonderful technology here. And it takes them no time, it is very quick, very effective. They are very well equipped, so they can carry out blood tests and monitor the heart all the time. And they let him out just in a few days, may be in four or five. Also, he hardly has any scars left, these are the kind of materials they use here, and just how caring they are.

Inna speaking of her son's post-accident treatment:

They stitched him together piece by piece! They raised him from the grave, in fact. I was amazed with all that technology in work, how they were doing absolutely everything they could.

An important part of the comfort of treatment is the care provided by auxiliary medical personnel. Migrants interviewed in this research did not speak of the qualification of nurses they dealt with. Instead, they highlighted their politeness and cheerfulness, which made them feel cared for, even when they themselves spoke poor German. Marina says:

What struck me, they were so polite and caring, all the time! With us, you can scream your guts out, no one would come. Like, when I was giving birth, you ask for a pain killer, and they just shrug shoulders. Here they will do everything for you, it is so much more humane!

Western scholars who have studied Soviet healthcare (Knaus 1982, Field 1987) have observed the lack of qualified auxiliary medical personnel in socialist medical establishments. Compared to the West, in the USSR a much smaller proportion of nurses were educated and employed, and their qualifications were significantly lower. And although the USSR was educating a higher proportion of highly qualified personnel (doctors) than elsewhere, medical professionals of higher rank did not engage in the

routine care work. A lack of nursing personnel meant that in (post) Soviet hospitals nurses were permanently overworked and underpaid, which had a negative effect on the quality of care they could provide to a patient. Hence, the bulk of routine care work, such as changing diapers, connecting and disconnecting drips, cleaning wards, administering medicines were (and often still are) carried out by relatives of the patient. Migrants take presence and qualifications of auxiliary personnel as a luxury and put it in a same context as clean bed sheets and functioning facilities. Nurses alleviate the work of the informal network inasmuch as they make and implement routine choices about care.

Technological progress and the availability of qualified auxiliary medical personnel do not oppose the traditional understanding of the doctor-patient relationship. Instead, they alleviate the burden the family would have to carry in case of hospitalisation in the ex-USSR, attending to a roughly stitched-up relative in an overcrowded ward. German 'comforts' leave space for familial interaction, without turning it into hard toil.

Hospital is a great achievement of the world of plenty, migrants suggest. This plentifulness, however, is rigorously managed and ruled, which persons socialised in the Soviet healthcare system regard as legitimate and necessary: major choices about treatment are made by medical experts, that is, doctors. To migrants, hospital treatment is the only context of German healthcare where patients are not permanently faced with the necessity to choose. With responsibility for decision-making shifting almost fully to physicians, the structure of the doctor-patient relationship, thus, takes a shape familiar to migrants from their previous experience. This shift acquires an important ethical meaning, as experts perform the role expected of them. As in the case of household-managed care, decision-making is being carried out by a legitimate actor.

In a hospital setting inequalities related to different insurance plans become less visible to migrants. The comforts and guidance they are exposed to by default makes them believe they are receiving a fair treatment, and almost none of the interview participants demonstrated awareness about the effects of insurance scope on the type of help they received (the exceptions will be discussed below).

Hospital treatment, as a special case of help-seeking and decision-making, exceptional in its organisation, demonstrates the nature of migrants' expectations about 'proper' healthcare: resources, including knowledge, must be distributed by a legitimate expert in a fair and empathetic manner. Giving birth is a special case of hospital treatment which illustrates the pursuit for control in great detail.

8.1.1 Giving birth

As mentioned in the methodological Chapter, the author of the thesis was visibly pregnant at the stage of conducting fieldwork, which often prompted her female interview participants to discuss pre-natal, maternal and paediatric care. Several of women interviewed had had experience of giving birth or undergoing pre-natal examinations in Germany, and some could compare it to an experience in Russia or other post-Soviet countries: Lena (who gave birth to all three of her children in Berlin), Galina (three children born in Kazakhstan and a fourth daughter born in Berlin), Tanja (her only child born in Berlin) and Natasha (who had one child in Moscow and one in Berlin). Also, a few native German interview participants had had a relatively recent birthing experience (Marlene, Monica, Lisa), and Stephanie was pregnant.

Unlike in the former USSR, in Germany pre-natal observations are formally voluntary. That is, a woman may refuse either gynaecological supervision altogether, or some specific components of examinations (such as ultrasound, blood tests, etc.). Whereas the former is done rather rarely, the latter is practised more widely. As with other spheres of German healthcare provision, pre-natal and maternal services are quite fragmented, with little connection between inpatient and outpatient services, and with a great spectrum of choice open to the person seeking help. Three major options are available for women to give birth: home birthing, hospitalization and the so-called *Geburtshaus* (Birthing Home). The majority of German women deliver their children in hospitals, however, home birthing is also growing in popularity (especially in the upper middle-classes).

Of the four German women either having had children recently, or about to do so soon (Stephanie), all were aware of the existence of the services available to them. Two of them, Lisa and Marlene, were decisively pro -'natural birth', which chimes in with their 'green' political beliefs, 'bio' consumerist strategies and non-biomedical help-seeking behaviours. After giving birth to her first daughter in hospital, Marlene decided she would never go back. To a great extent, her beliefs resulted from the encounter with 'traditional' culture in South Africa, where she worked as an NGO engineer:

I could see there how much stronger these women were. They were independent. They had a strong connection with their child, and no one was standing between them and their newborns. I realized that hospitals were totally unnecessary, I did not want that impersonal, rude setting to spoil my experience

of having a child.

Marlene romanticises the 'natural' lives of African women and projects them onto her own experience: for her 'natural birthing' is a reflection of 'fair world' beliefs and environmental awareness. However, her next pregnancy ended in the hospital, as complications with twins arose. Her dissatisfaction with biomedically managed birth was enormous (as discussed in the previous Chapter). Finally, the last child was born at home, as Marlene was assisted by an obstetrician and her husband. They both say it was the best birth they have experienced.

Lisa's first pregnancy was planned to end in the Birthing Home, which allows a lower level of medical intervention than a hospital birth. Seven years ago, when it was to happen, that Home was the only one in Berlin, located in a highly gentrified neighbourhood of Prenzlauer Berg. Although her pregnancy did not appear to have any complications, several problems arose during the birth, and Lisa was transferred from the Home to a nearby hospital by her obstetrician, for an assisted delivery. Her second birth in the Home, however, ran smoothly, and she was greatly satisfied with all the attention and care she got there.

Monica was supportive of the idea of Birthing Homes, however she gave birth in a large hospital herself, given that she was pregnant with 'high-risk' twins. Stephanie, however, rejected the idea of 'natural' birth and lack of medical supervision.

I think, it is dangerous. I mean, I do not mind other people doing it, but I want to have everything in case there is a complication with me or with the baby.

Stephanie, like Lisa was a doctor, but Stephanie also had a long-term reliance on medical help, caused by a complex chronic illness which, perhaps, underpins her desire more for medical supervision. Unlike the other three women, Stephanie grew up in the GDR, in a family of doctors. She strikes a strong resemblance to *all* migrant women I have spoken to about childbirth. In fact, their solidarity in issues of birthing was striking, given otherwise strong discrepancies in health beliefs and help-seeking strategies: Moscow-born, *Heilpraktiker*-reliant, bio-cooking Natasha, and Kazakhstan-born sporadically seeking help Tanja agree that a woman should only give birth in a hospital, under close supervision. Lena, whose anti-Russian and anti-Soviet beliefs are very firm, and Galina, who thinks Kazakhstan has a better healthcare system than Germany, both opt for a

hospital, too. These firm beliefs are related to gaps in the information some of these women have about the available services: Tanja, for example, knew nothing of obstetricians, only seeing a gynaecologist, and Galina had only a very vague idea of what a Birthing Home was. Lena and Natasha, both self-funded, were aware of all available options, but strongly preferred hospitals to everything else.

The beliefs of these women, so different in their backgrounds and their socio-economic mobility in Germany, are likely to be explained by a pervasive *tradition* of the medicalization pregnancy, characteristic of the former Soviet Union. Maternal and paediatric services composed a significant part of healthcare facilities in the former USSR, and were organized centrally. Special facilities were designed to control women's and children's health: women's medical consultancy centres for routine check-ups and pregnancy supervision; special birthing hospitals where virtually one hundred per cent of children were born, especially in the urban areas; and children's hospitals and polyclinics. Pregnancy supervision was not voluntary, and all examinations were imposed on a woman by medical professionals. After the collapse of the USSR, little has changed in the understanding of women's role in the decision-making process: as Rivkin-Fish demonstrates, birth and pregnancy remained conceptualised as high-risk events, and women were expected to be fully compliant with expert knowledge (Rivkin-Fish 2005). Partners and relatives were not allowed to be present in the hospitals. New 'western' ideas and practices became unevenly introduced to the poorly staffed and poorly financed healthcare system, with 'natural' and 'family' birthing becoming a privatized privilege of the better-off classes. Controlling women's and reproductive health remains a great ideological pursuit of modern Russia.

Having been socialised in a medical system which generally sees birth and pregnancy as a high-risk situation in need of medical management, these women chose the highest degree of medical supervision in Germany, too. Such a medicalised strategy may seem to go against a woman's health beliefs, which is especially clear in case of Galina, who announces:

Pregnancy is not an illness! Forget what they told you in the USSR! It is a natural condition to be pregnant, and you will be totally fine!

In the course of our conversation, Galina also praises the benefits of long-term breastfeeding and recommends several books about the non-biomedical treatment of

newborns. She demonstrates her pro-active approach to popular 'Western' health beliefs and a willingness to 'shrug off' her socialist past. However, when it comes to medical help, especially in the realm of maternal health, she presents with the traditional model of expert dominance and patient compliance.

In fact, Galina does not mind being treated a bit rudely, if she can attribute intervention to qualification and expertise. She speaks with a degree of awe and astonishment of her latest birthing episode:

We arrived to the hospital a bit early. I mean, I have had three kids before, so I thought this one will go very quick. So, we walked and walked, waiting for the labour to start, but nothing was happening. And I was getting really tired. My hospital obstetrician looked quite scary, I must say. I had taken a dislike to her immediately. She was a bit of a Soviet kind, commanding around. And when nothing was happening for hours, she told me to lie down, and then she just pierced me there with her finger really painfully. I almost screamed at her, it felt very rude, very painful, and she just told me to be patient. But then the labour started immediately, and the baby was born in half an hour! I was afterwards very grateful to this woman for doing it. Perhaps, with birthing women one needs to be a bit pushy, they do not really know themselves any longer.

Natasha speaks of her pregnancy supervision and birthing experience in Moscow:

In fact, they were really good in that local maternity clinic. OK, I had blat elsewhere for birthing itself, but there they really cared, too, they controlled you. I went into labour a week before I was expected to, and so I did not show up for my last scheduled examination. I only came a few days after birth to get some papers. And that doctor, he saw me in the corridor, he did not even notice I was not pregnant any more, and screamed: Petrova, what the hell, immediately come into my office I must check you up! You are crazy, you will have complications at birth, will risk your child! March now into the surgery! And I just laughed, hey, don't you see I have already had a baby. And he laughed, too, then, you could see, he was a good, caring man.

She then continues to discuss a birth in a German clinic:

I had arranged everything to be birthing with this Lithuanian obstetrician, you know, everyone knows her, all Russians go to her. She is very strict, no nonsense, but she is very good. She tells you what to do, so that you don't let yourself go.

Eventually, however, Natasha gave birth with a German obstetrician, again going

into labour too early and having to be hospitalized urgently. She does not reflect much on the birth itself.

What is important from these excerpts is the women's expectation to be controlled and the importance of 'keeping the upper lip stiff' (*ne raspuskatsja*) and of 'being patient'. Indeed, otherwise vested with power to make health-related choices for their families, in a situation of birthing women are supposed to subordinate themselves to experts. They explain the necessity of being 'controlled' by a troubled state of mind a pregnant woman may be in (Galina) or by health risk of birthing not supervised medically (Natasha). Indeed, being the main care providers in their families, they themselves may feel they have no other informal help to rely on, and thus, their dependency on professional care may grow. Besides, unlike German women who have recently had children, migrant interview participants speak much less of their partner's role throughout pregnancy and birthing. Although men were present at birth in all cases, their participation was much less proactive than in the German families. In all cases they were not present during the decisive moments of labour (unlike the German men), waiting outside the ward for the baby to be born. Even in the cases of Lena and Natasha, who have German partners, the 'Russian' gender division of roles remained unchallenged, with women drawing more strongly on the help of medical experts, rather than their family members.

All women distinguish strongly between 'Russian' or 'Soviet' and German medicine, seeing the latter as better in the case of birth. Of all the women who gave birth in Germany none, in fact, had directly experienced *extremely* poor maternal care in their sending countries. Whereas some were able to manage birthing by *blat*, others, in fact, never gave birth or received other forms of maternal care in the ex-USSR. Episodes typical of biographies of the formally disadvantaged, such as Emma's experience of abortion carried out without anaesthetics, or Marina's memories of giving birth in a village hospital almost unassisted, are not a part of these women's life experience. However, these women demonstrate awareness about the poor state of maternal care in their countries, constructing a highly negative image of obstetric and gynaecological help back 'home'. Natasha, who had powerful connections in Moscow's medical world says:

Even if you do it with blat, it cannot compare. Because the conditions themselves... Here everyone is just so friendly! It is a celebration that a new baby is born, for everyone! They are happy for you! And there no one cares, it is a conveyor. Here you are in a clean ward with your child, there is everything for you both, diapers, baby clothes, bed sheets, it is all clean and done with care.

Lena, whose last pregnancy was supervised both in Moscow and Berlin, experienced an adverse event in the first trimester, and was urgently hospitalised to a private clinic in the centre of the Russian capital. The clinic, in fact, caters to the needs of expats and other foreign citizens in Moscow. Given that Lena's partner is a high-ranking German investment banker it is not unnatural that the family chose that clinic. Lena says, however:

It can be as luxurious as they want, but it is ridiculous. It smells like money there, nothing else. They lick your ass, but in fact, they do not care.

Lena contrasts that 'glamorous' clinic (she humorously calls it 'glamurnaya') to a rather run-down public hospital in Berlin where she gave birth twice before:

That hospital, you know, it is right in the middle of Kreuzberg, so all these huge Turkish clans have babies there. And it is so cool there, so lively. All these people basically making picnics in the hospital corridors waiting for the child to be born. Everyone is celebrating all the time, a really wonderful atmosphere. And the day I was there for my first birth, in fact, somebody robbed the hospital kitchen, you know, it is a poor neighbourhood, loads of tramps around. So, they were very, very, very apologetic about giving us bread with cheese. It was so sweet of them, how hard they tried!

Galina also mentions the work of auxiliary personnel in Germany:

I think we have good doctors. But there are too few of them, so a woman is left alone in birth. You feel lonely, you are left to yourself. And here the nurse is always with you, or an obstetrician. You never feel alone, you feel safe.

Russian and German medical care are opposed to each other in terms of quality of the doctor-patient relationship, not in terms of the quality of medical expertise. Women talk of being treated with more friendliness and politeness in the German clinics. As in other cases of hospitalization, they do not question the necessity of rigid power inequality and strong intervention, however, they appreciate the 'humanism' which accompanies it.

By seeking the highest degree of medical intervention, these women follow the tradition of maternal health supervision they have been socialised with in their sending countries, which has a gendered division of roles. In the realm of maternal care socio-economic differences and identity variations seem to have much less impact on health

beliefs than the general experience of socialisation in the socialist healthcare model.

8.5 Nursing Care

When I ask Ludmila whether she thinks there is a difference between how medical help is provided in Russia and in Germany, she exclaims:

Russia! Russia is a far cry from Germany! (Nebo i zemlja) Because the first, most important issue here, is social security. It is the most important thing! Here a person can afford to be ill, being ill and receiving medical help. In Russia it is absolutely out of the question. It is very sad. Here you feel this social security everywhere, all these wheelchair ramps, elevators. For someone it may seem like a petty thing, but I know what I am talking about. My uncle, he lived in the Ukraine. And all his life he worked in a factory, in the hot shop. He worked all his life and never had a rest. And when he retired, he got diabetes. He had a wheelchair, and he had not been outside, out of his flat for three years. For three years before he died. Because no one could carry him downstairs. So, social security here is not comparable!

Professional nursing care or *Pflege* provided by certified agencies and covered by medical insurance is one of the most important components of 'humanism' mentioned by interview participants alongside good housing and general safety of the 'world of plenty'. Unlike in the case of other outpatient services, all persons relying on *Pflege* or having family members receiving it, expressed great satisfaction with the quality of help they received. Those who do not use such services were, however, aware of their existence and also shared a very high opinion of them. As in the case of other components of medical care, *Pflege* was reflected upon in terms of the difference between the sending and the receiving country. In fact, as I mentioned in the methodological section, all interview participants use strictly German terms for describing nursing care: the Russian analogues are either conspicuously non-existent (pointing to non-existing structures), or are tabooed to such an extent that one does not use them to talk about one's own life or family. All the terms used by migrants in German have been left in the original language in the following excerpts. Misha says:

Who should help disabled people? You mean like elderly and Pflegefaelle? Well, if everything goes like now, than, certainly, professional help is very good. I can see that there are competent personnel involved, and the family, too. I think in Germany it is on a very good level. I do not know whether there is Pflege in Russia. Probably not. And if there is, they are just probably waiting for them all to die to get the money or their apartments, I do not know. I mean, I exaggerate, but I know that everything is very expensive there, only very rich

people can afford the kind of Pflege one can have here.

The purpose of *Pflege* is to assist persons disabled physically by illness or old age in their everyday lives. They often assist with the most mundane tasks, such as taking out the trash, cleaning up or cooking, and are also certified to carry out hygienic and most basic medical assistance. Professional caregivers thus become drawn into the internal lives of the households where they are to help and become members of the informal network.

Although, as discussed in Chapter 5, Russian German identity is strongly determined by reliance on help within the extended family, disabled or elderly Russian Germans, in fact, accept *Pflege* very eagerly. *Pflege* does not contradict their beliefs about help to be provided informally by other family members. In fact, *Pflege* does not challenge traditional generation and gender roles, it only significantly alleviates the burden of help each person is supposed to carry. Cast against informal help, it is also conceptualised as reliable and professional.

Albert who has just filed an application for *Pflege*:

Of course we want professional help. It is very good to know that someone is going to come on a particular day or particular hour and do the job. It is good to know they do it because they are trained for it. Relatives are always busy with other things. They have jobs, they have friends... Today they come, tomorrow they do not. So, it is better it is done by a professional.

Irma:

I am very satisfied with my Pfleger [Irma changes the word so that it signifies a female caregiver]. She does all I tell her, and she is professional, she is paid for this job. If I do not like what she does, I can change my Pflege provider. Thank God, there are enough of them.

Thus, *Pflege* is a liberating alternative to dependency on the mercy of other family members. *Pflege* offers autonomy without frustrating with choice. It provides expert knowledge and technology on one's own territory. Provision of *Pflege* does not interfere with the core of generation and gender roles, whereas the role of a family expert remains attached to women; by making use of *Pflege* they are able to enhance the scope of help, however, they remain in charge of the situation, distributing the tasks. This manifests itself, first and foremost, in the process of decision-making related to the application to *Pflege*. In

all families but one (Erwin and Kristine) it was women who decided on behalf of the household that it was time to start receiving *Pflege*. In the case of Erwin and Kristine, the husband is militantly against a 'stranger' coming into the house, and resists applying for help. It was also the women who would carry out or arrange the application for a *Pflegestufe* (disability registration). For example, Larissa took charge of Mikhail's documents for his application; Tamara made sure her husband's carer came on particular days; Nina was in charge of choosing a care provider. Given that women are considered to be informal caregivers, the task of alleviating the daily burden of work is attributed to them as well. It is also women who distribute tasks once *Pflege* becomes embedded in the household's everyday routine. Tamara tells of her experience with *Pflege*:

I tell her what to do. For example, I tell her to wash the windows, or de-frost the fridge. Or maybe clean up the balconies. We try to do a lot of things ourselves, but for some things we are too old. I cannot ask Grisha [her husband] to do some things anymore, and Ilya [her son] is away in Moscow all the time. So I have to ask Pflege.

Tamara's husband Grisha, in contrast, seems to make no decisions about what the *Pflege* is to do around the house. A similar situation can be observed in the household of Galina and Sergey, who are significantly younger than Tamara and Grisha and have a different background, coming from Kazakhstan. Sergey's sister, who is severely handicapped, lives with his mother and receives *Pflege*. She is also periodically placed in a nursing home, whenever her condition worsens or the family is unable to take care of her routine. Galina says that everyone takes an equal part in orchestrating the tasks. However, her words suggest that it is women who do the managerial job:

G: Sergey drives her when necessary... Or shops for some heavy stuff, like, you know, buying things in bulk in advance. His mom is also too old to carry bags. And we all take turns in visiting them and cleaning or washing. Pflege is good, but it is not enough when you have an old person and a disabled woman living together.

P.A.: Who decides on whose turn it is?

G: Oh, it is quite natural... I usually give tasks to everyone. Or his mom calls and says this and this needs to be done, so I decide who will do what. Like, I would tell him he picks up the kids, and I go there. It is common work.

Although Galina claims it is 'common work', managing help and embedding it into the life of a household still remains the role of a middle-aged woman. Thus, there is no strong contradiction between reliance on an institutional form of help and tradition. *Pflege* is regarded as a legitimate alternative to informal help because it does not exclude informal help altogether, it serves as an important, but somewhat 'luxurious', addition to it.

However, although theoretically greatly desired by many persons, *Pflege* is unequally accessed by different groups of migrants. The size of the family, its experience in the sending country and the distribution of traditional generation and gender roles in it serve as decisive factors. Let us look at Ludmila's family as a telling case.

As mentioned previously, Ludmila survived a devastating car accident only a year after arriving in Germany, and since then has experienced several degrees of disability: from full physical incapacity, confined to a wheelchair, to difficulties in walking and lifting weights. Altogether, Ludmila has several complex surgeries and many hours of rehabilitation treatment behind her. However, most of the time, including the period of severe disability, she did not draw on *Pflege*. She argues, she was not aware of its availability. First, as in the case of hospitalisation, the missing institutional link between different sectors of medical care results in a care gap:

My first surgery was five years ago. After it I felt horrible, I was immobile. I was all covered in iron. And no one, not a single person advised me on anything. No Pflege, nothing. I had to receive medication shots daily, and my family was doing it for five months. I could not bathe. That is clear, I was immobile, I could not climb into the bath tub. So I was just wiping myself with a towel. And no one, no one told me anything. Then there was a second surgery, and a third one, and still, no one, nothing.

Second, her previous experience had not prepared her for the possibility of such services:

We got used to the fact that in Russia there was nothing. We could not even imagine that in my state I would be subjected to Pflege! We did not even hope! Thank God, we thought, they made me a surgery and supplied me with medicines!

Her unawareness results from her great reliance on informal help provided by her extended family. The experience of material disadvantage in several generations, has led to an extremely rigid distribution of generation and gender roles. In relying on tradition, Ludmila, in fact, had a powerful resource of help:

L: I have not had Pflege for a very long time. Because my whole family was helping me. Although I have had very tough periods. But I was simply unaware. For three months I could only stand with one foot. Now it is funny, but back then it was horrible. I could do nothing. I did Hoover a bit, even though it was forbidden, but I tried, but then I stopped. I still cook sometimes, although it is hard. Of course I need Pflege. In my state! However, you know, when your family is taking care of you, it grows stronger. It does not leave you. It cares more.(...)

P: How do you decide who is to do what?

L: Oh, there is nothing complicated about that. It just runs the way it is. Everyone does whatever they can. For example, I will not send my daughter to the shops. She should not carry bags. Instead, my husband, a big sturdy guy, will do that. And at the same time, I will not ask my husband to look through the correspondence. My daughter will do it better.

P: How do you ask for help?

L: I do not really have to ask. Everyone knows what is expected of them. My husband will not wash the floors, that is clear, isn't it? My daughter does that. My husband can Hoover, though. Cooking is done by everyone.

P: Do you discuss the day in advance? How does the discussion happen?

L: We do not really talk about it together. I am the brain behind it. Thank God, my head is intact, so I can distribute tasks. I am not doing so well physically, but I can take care of things. I understand that my daughter is very busy, she gets tired and forgets things. So I remind.

At the same time, Ludmila's elderly female relative is also reliant on the informal help of the extended family. Ludmila says that 'everyone is taking turns in caring for her'. However, the old woman submitted an application for *Pflege* many months before Ludmila filed her documents for the insurance company, too. Ludmila was not informed about that. In fact, she seemed to block the discussion of this topic, by suggesting she had no legitimate reason for asking the relative for advice:

I can not say anything about Grandma's Pflege. In fact, I should not say anything at all, because I am helping her least of everybody. Because I can't.

Thus, whereas both women suffering from physical disability were embedded in the same informal network of care, only one of them, the older one, and the one with

experience of stronger discrimination and poverty, was legitimised to seek professional help.

Grandma says, she sees Heaven on Earth already. Because she had a very tough life. Deportations, labour army, war, hunger... And hard work, very hard work all the time. So, now she is very happy.

The older woman's application for *Pflege* was hard-earned, and Ludmila felt she did not have enough authority to draw on her experience. On the contrary, Ludmila speaks of losing authority due to illness in several instances, for example:

Now when children speak so much better German, I feel that I am losing authority.

or

Poor children, they have it very hard here. And besides, their mom is good for nothing, always being ill.

Not seeking information about *Pflege* pro-actively, and complaining of not being informed about her right to draw on it by medical professionals, Ludmila found out about her rights from other disabled persons in her rehabilitation gymnastic class.

L: I started doing this ReHa [rehabilitation treatment], and imagine, all people there are like that, too. But they are more educated than me. And they told me of everything. They were shocked I had no Pflege, and told me I had to apply for it.

P: Who were these people?

L: Oh, mostly locals. Not many migrants. I mean, there were Poles, and Germans and some Jews, but no Russians. But mostly Germans. So they live here long, and they could tell me of their experience.

However, neither of these persons could help Ludmila to draw a file proving her need for *Pflege*. To fulfil the bureaucratic requirements, she turned for help to another informal contact, a friend of her daughter working in a large social work establishment, whom she said she met by 'pure coincidence'.

Thus, altogether, Ludmila's path into *Pflege* had been assisted by informal contacts,

which at different stages delivered different information to her. Although reliant on the help of younger or same-age family members, she never sought help from an elderly relative who, in fact, had experience she needed to draw upon. Instead, she used the contact of her daughter. On the one hand, reliance on the resources of the extended family has greatly assisted Ludmila. On the other hand, it prohibited her from effective search for professional help, thus, perhaps, jeopardising her health:

Now, when I submitted an application for Pflege and was examined, then I was told by some people... Some people who really know what they say... They told me, goodness, how is that possible, you have survived the most tough period without Pflege! It was suicide! You should not have done that, you risked!

Thus, in Ludmila's case the most important information about available care came from external informal networks, not from her care providers and not from her family. Her case demonstrates the importance of migrants' inclusion in networks of 'locals' or established migrants with other backgrounds ('Jews' Ludmila refers to): they lead to resources not available by means of one's own community. Indeed, Ludmila's case demonstrates the 'strength of weak ties' (Granovetter 1973).

At the time of interview Ludmila was looking forward to receiving *Pflege* soon. She believed it would alleviate the burden of labour she was imposing on her family without, however, threatening the tradition of the extended, pre-figurative family. She believed that her reliance on *Pflege* would be beneficial to all family members in pursuits, otherwise expected of them: education and work.

I understand very well that when children are successful, and if they work, or study, they cannot nurse anyone. It is only possible if the person is, let's say, unemployed. Then one can give more time to other persons. But otherwise it is impossible. I need professional help.

Other persons I have interviewed had different pathways to *Pflege*. In all other cases migrants would find out about *Pflege* as an existing opportunity from persons in their own private network, mostly from the extended family (Tamara and Grisha, Larissa and Mikhail) or neighbours (Albert and Nina, Irma, Bella). Once the initial information had been considered, persons would seek help from different migrant organisations. For example, Albert and Nina have sought advice from the Russian Germans' Landsmen Union. Albert

says:

They recommended that I see a doctor, a professor, who immediately confirmed I needed Pflege. And then we came back, and they helped us with drawing the papers together. It was very friendly, they worked very quickly, like I am a brother to them or a father.

Larissa sought advice in the NGO consultancy centre where I met her, an organisation otherwise running educational and cultural events for Russian Germans. Irma, one of the few persons who speaks better German than Russian, in fact, filed her documents herself. In the case of Jewish migrants, the Jewish community serves as an important point of entrance. Not only does the community run its own *Pflege* service and a nursing home, it also offers help with filling in all necessary papers. Tamara and Grisha received all help from their adult son. Unlike Ludmila, all these people belong to the oldest generation of interview participants. In their case, reliance on *Pflege* is regarded by younger persons as a 'natural process' (as Misha puts it: 'they grow weaker, and it is natural that they need *Pflege*'), and there are fewer social and cultural hurdles on the way to professional help, as compared with Ludmila's situation.

Reliance on *Pflege* spares time and energy for other activities family members consider important for themselves. Ludmila hopes to be able to visit the Marzahn Community Centre more often and take part in its cultural program. Tamara and Grisha, as well as Bella, say they go to the Opera, because 'they have time'. Albert and Nina see their children more often, given that they do not have to 'strain themselves'.

The deep inclusion of *Pflege* into tradition and the life of the family, with its generation and gender roles, is also explained by the fact the all migrants I have spoken to rely on services of Russian-speaking *Pflege* providers. Indeed, in Germany nursing care is a rapidly growing labour market for Eastern European women. On a practical level it means, on the one hand, that disabled persons are being catered for by other migrants from similar backgrounds (mostly, female). On the other hand, it means that a great number of families has women employed in this sector and is familiar with its internal structure. This leads to familiarisation of services in the most direct sense. For example, Irma's caregiver comes from the same Kazakh village. Irma has known her for her whole life and calls her tenderly '*dochenka*' (daughter). At the same time, Irma's daughter-in-law also works in a nursing home, as do Emma's and Albert's younger female relatives. This labour market situation makes it impossible for some old people to expect help from

members of their immediate family, given that they do nursing work all day long elsewhere. However, they may receive such institutionalised help from the extended family or from members of informal networks.

Russian-speaking *Pflege* services, however, seem to be fragmented along the lines of migratory processes and the communities resulting from them. Whereas some services mostly cater to Russian Germans, others rather provide help to Jews and self-funded migrants. This theme has not been studied in detail in this thesis, opening prospects for further research.

Reliance on the services of persons with similar background also satisfies needs resulting from migrants' specific situation in Germany. For example, all migrants drawing on *Pflege*, with the exception of Irma, mentioned their *Pflege* carers translating their correspondence, making important phone calls on their behalf and accompanying them to doctor's appointments. Neither care providers nor care recipients regard these special services as something unusual, instead, as a chairwoman of the social work department in the Jewish Community suggested, they were a necessary part of care.

Of all the options of care provision, *Pflege* seems to be most strongly intertwined with traditional family structures and is regarded with equal satisfaction by migrants in all SES and identity groups.

Summary

The inpatient setting, along with ambulant nursing care, make up two sectors of professional healthcare migrants express most satisfaction with, regardless of their socio-economic background and identity. This satisfaction results from the overlap of these forms of care with different traditions of care and help provision practised in migrants' families and informal networks.

As for the inpatient care, it agrees with the traditional sick role and division of power in the doctor-patient relationship, whereby the expert is supposed to be vested with the power of decision-making and the patient is expected to demonstrate compliance. The universal agreement across all groups of migrant women about the necessity of close medical supervision during birth suggests that in specific health-related contexts the socialist medicalised understanding of health plays a role of universal culture, uniting persons with very different socio-economic backgrounds.

The case of nursing care suggests that institutionalised forms of care need to be embedded into the familial context in order to be received as efficient and desirable. As long as nursing care is managed by the care recipients themselves or by lay persons having a legitimate reason to do so, their satisfaction with it is great. Autonomy which they acquire through such help is not regarded as unethical (as in the case of outpatient services), but as a benefit for informal care providers, spared of an extra burden.

Conclusions

This thesis has described the relationship of health beliefs and help-seeking practices to people's identities. Focusing on migrants from the former USSR to Germany, and collecting direct accounts of change from persons comparing their lives 'there' with their lives 'now', I traced the ways that beliefs about health transform throughout the migratory process. I have gathered migrants' own conceptualisations of health, and demonstrated that beliefs about health shared by members of different 'Russian' communities are very diverse, being determined by individuals' socio-economic background, cultural heritage and migratory process. Qualitative research permitted placing health beliefs into biographical perspective and explore the relationship between identity and health beliefs, as set out by the research question.

As discussed in the literature review, some existing research tends to over-generalise the effects of socialist ideology on individual health beliefs and help-seeking behaviours. William Cockerham (1999, 2002) proposes that the USSR has created a Homo Sovieticus (Cockerham's spelling), a person, on the one hand stripped of opportunities to make decisions about health, and, on the other hand, unwilling to take individual responsibility for himself. Explaining the mortality and morbidity toll of the 1990s, Cockerham attributes high rates of death in blue-collar men to their socialist ideological beliefs and resulting unwillingness to accept liberalisation and to change their lifestyles (Cockerham 2002). Cockerham's thinking is, to some extent, projected on migrants from the USSR abroad: research in Israel also tends to explain low rates of preventive care in former Soviet women as a result of their 'socialist' minds (Remennick 1999; Remennick 2003). Cockerham's research offers an important insight into the collective experience of disempowerment that the majority of Soviet people felt in their everyday lives, however, over-stressing socialist ideology in favour of socio-economic factors seems to be a biased approach, which casts Russia and the former USSR republics as 'special' places, profoundly different from the West. The reasons some segments of the Soviet population held fatalistic health beliefs are not (or not only) rooted in ideology; instead, passive health beliefs resulted from reasons applicable to people with low socio-economic status in all societies. Research by Shkolnikov and Andreev (Shkolnikov, Cornia et al. 1998; Shkolnikov, Leon et al. 1998; Andreev, Nolte et al. 2003) demonstrates that in the 1990s dangerous behaviours and neglect of health were

characteristic of poorly educated manual classes, males being more affected than women. Whereas health of these people deteriorated very quickly, with medical services unable to compensate for the effects of economic transition on individuals' well-being, other social strata remained fairly untouched by the post-communist morbidity and mortality crisis. Demographic analysis, as well as sociological and anthropological research demonstrate that exacerbation of socio-economic inequality in post-Soviet society is a stronger explanation for proliferation of passive health beliefs, than individuals' personal adherence to communist ideology.

Research by Nina Rusinova and Julie Brown (Brown and Rusinova 1993; Brown and Rusinova 2002; Rusinova and Brown 2003; Brown and Rusinova 2011), by Michele Rivkin-Fish (2005) by Galina Lindquist (2002, 2006) and by Anna Temkina (Temkina 2008) demonstrates how different 'soviet' health beliefs were, and how various their transformation processes are. Publications by Rusinova, Brown and Lindquist on relationship between socio-economic status, cultural traditions and health beliefs in the former Soviet society helped me understand differences across the groups of migrants I studied. In particular, in Chapter 3 I drew on an analysis of the effects that informal social networks played in gaining access to healthcare services that Brown and Rusinova present in their publications (Brown and Rusinova 1993; Rusinova and Brown 2003). Research by Michele Rivkin-Fish helped me to develop a deeper understanding of how informal exchange within post-Soviet healthcare setting worked, and which inequalities it was related to (Rivkin-Fish 2005). Galina Lindquist's analysis of pathways into non-biomedical treatment helped me to understand migrants' beliefs about traditional healing. This knowledge about different settings of initial socialisation helped me understand the transformation of migrants' health beliefs. This literature was necessary to explain migrants' interpretations of the German healthcare system and their beliefs about the effects that migration had had on their health. At the same time, approaching migrants' families as settings of primary socialisation, Margaret Mead's conceptual apparatus (Mead 1970) proved to be helpful in explaining how health beliefs are transmitted in the family setting, and how their relationship to generation and gender roles is established. The concepts of pre-, co- and post-figurative cultures also helped me explain the ways in which migrants' families are transformed in Germany (in Chapter 5). Finally, the notion of identity boundaries, adopted from Barth's approach (Barth 1969), proved crucial for explaining ways in which various migrants' communities describe themselves and others, and how they change their beliefs about health. I demonstrated that once groups of people, previously unaware of each others' existence, become drawn together in a same category, they actively negotiate and transform their identities.

Retrospective analysis. Establishing the core concepts: *Kul'turnost* and *takaya zhisn*

Studying the descent and development of health beliefs and help-seeking practices in different migrant communities, I trace them in the context of the socialist stratification system, marked by vital importance of social capital (informal networks), on the one hand, and regional inequalities, on the other. I demonstrate that Russian German migrants, mostly coming from an agricultural background, and contrast to formerly urban-based Jews, the two major groups of ethnic minorities constituting the body of ex-USSR population in Berlin. I distinguish three groups of persons with respect to their backgrounds and health beliefs: the ex-disadvantaged (rural Russian Germans with all degrees of educational attainment), the ex-fragmentarily empowered (first-generation urban intelligentsia and skilled workers, mostly Russian German) and the ex-privileged (established urban intelligentsia, mostly Jewish). The health beliefs of these different groups oscillate between the concepts of *kul'turnost* (культу́рность - being cultured') and 'takaja zhisn' (,taking life as it is' or ,that is how life is').

Kul'turnost makes up the core of identity of persons who have previously belonged to the categories of 'privileged' or 'fragmentarily empowered' in their sending country, as well as in accounts of a formerly 'disadvantaged' family with higher education from rural Kazakhstan. In their accounts of a 'cultured' approach to health, *kul'turnost* has two major functions: the pro-active pursuit of knowledge and resources for implementation of this knowledge, on the one hand, and segregation of 'others' into categories of 'uncultured', on the other. Pro-active, individualistic health beliefs expressed by the concept of *kul'turnost* are related to a sophistication of help-seeking practices which had been employed by all privileged and by some fragmentarily empowered persons in their sending countries. The ex-privileged urban intelligentsia was able to act upon their beliefs by mobilizing their informal networks, taking part in a complex system of informal exchange necessary to maintain balanced nutrition, gather information about health or reach medical professionals of the highest rank. Their high evaluation of health as an individual achievement was supported by their socio-economic position and by their family structures: mostly composed of nuclear families, urban intelligentsia relied on powerful 'weak' ties. To refer to Mead's conceptual apparatus, their families tend to have *pre-figurative* structures, with the oldest generations expected to learn from the youngest. The values of progress and modernity promoted in these families implied familiarity with scientific discourse on health. As Galina Lindquist suggests, even non-biomedical treatment options these people sought, were characterised by a quasi-scientific, evidence-

based approach (Lindquist 2002).

The situation of the fragmentarily empowered was more precarious. Although they also tend to determine health in pro-active terms of *kul'turnost*, they were more limited in their ability to act upon their beliefs. As a first generation of urban intelligentsia or manual skilled class, they had better options to maintain their health and seek medical help than persons in the rural areas. Having separated from their families through transition into an urban setting, they established a type of family Mead calls co-figurative: a structure based on interaction of persons in a same generation. Unlike the privileged established intelligentsia, they did not have enough connections across various social strata to exercise informal choice in the restrictive and shortage-ridden Soviet system. At the same time, reliance on support of the extended family was also not an option any longer. Hence, fragmentarily empowered people drew on help of persons in the same generation and social class. In particular, in seeking to be in charge of their health, they grew dependent on services available through statutory system and expected a 'controlling attitude' from medical professionals as a marker of commitment and qualification.

The concept of *kul'turnost*, which refers to the ability of an individual as an autonomous agent to affect his health, is intricately related to the notion of *takaya zhizn* which embraces migrants' understanding of structural empowerments and constraints which determine their lives. This notion addresses one's self-identification with a collective tradition of behaviour in the extended family: 'this is how life is, how we all live it'. As a health belief, it refers to circumstances which seem to be objectively affecting one's health. Understanding of health in these terms is particularly expressed in the formerly disadvantaged persons, who attribute their health to external factors: work, genetic factors and cultural tradition 'imposed' on them through generation and gender roles of their extended families. Post-figurative family, with its orientation towards past experience is an important source of such health beliefs. At the same time, 'taking life how it is' also pertains to the conceptualisation of particular health determinants in fragmentarily empowered and privileged groups, of which natural environment is the most important one. 'Taking life as it is' should not be reduced to fatalism (although, sometimes it may indicate a fatalistic approach). Although some aspects of life may be taken 'as they are', such as natural environment or housing, choices can be made in other realms of life (nutrition being the most prominent).

The analysis of descent of migrants' health beliefs and help-seeking behaviors demonstrates that folk conceptualisations of health are strongly related to identities adopted by different persons under various circumstances. Although people's beliefs about

their ability to influence their health depended strongly on their ability to reach out for medical help, their general approach to health was shaped by other socio-economic circumstances and cultural heritage. In disadvantaged persons it resulted from self-identification with collective values of extended families, constrained by poverty and organised by agricultural labor. Fragmentarily empowered people, in contrast, build their identities through the experience of the individualistic pursuit for mobility in urban setting, and the privileged identify themselves with values of 'high' culture.

Migratory process and transformation of health beliefs and help-seeking behaviors. Westernization and transition into the world of plenty.

The initial differences across groups of migrants have a significant effect on the distinct ways they re-evaluate their attitudes to health and adopt new help-seeking strategies in Germany. In chapters 5 to 8 I look at transformation of ideas about health throughout migratory process. I demonstrate that socio-economic gradient of the receiving society becomes irrelevant for explaining differences in health beliefs, given that a significant proportion of migrants, regardless of the initial levels of qualifications, experience downward social mobility. Instead, I argue that internal stratification of migrant communities in Berlin results from persons' participation in distinct types of migratory processes. In that respect, carrying out fieldwork in two neighbourhoods with very different history of 'Russian' presence proved as a successful strategy. Throughout fieldwork in Marzahn and Charlottenburg I was able to trace a variety of migratory processes, leading to formation of distinct communities, with their own identities and boundaries. Place of residence does not only shape identity by including into or excluding from distinct networks, it also indicates descent and status. In Chapter 3, where I treat the ex-Soviet population of Berlin through the lens of Vertovec's 'super-diversity' (CITE), I demonstrate that the 'Russian' migrants in Berlin are anything but a heterogeneous group of people. Differences between those people who settled in Charlottenburg, and those who live in Marzahn, can be explained by differences in time of arrival; in initial motivations; in political environment prohibiting or, in the contrary, stimulating migration; in legal status; in relationship to the sending country, and in many other aspects discussed throughout this thesis.

On the basis of material gathered in Marzahn and Charlottenbutg, I distinguish between institutionally-funded migration which has enabled the re-settlement of Russian German and Jewish ethnic minorities, on the one hand, and the self-funded autonomous

migration, on the other. Russian Germans and Soviet Jews were supported by the German state throughout all the stages of their migratory processes, being formally regarded as returning expatriates or prospective members of the Jewish communities. In contrast, the self-funded persons needed to carry out all steps related to overcoming exit and entrance barriers on their own. Throughout the thesis I demonstrate that involvement in either institutionally-funded or self-funded migration is associated with inclusion in distinct social networks. Whereas institutionally-funded migrants are more likely to rely on strong ties within their extended families and members of the same migrant cohort, self-funded migrants maintain a variety of weak ties to persons long established in Germany, that is, either earlier migrants or native Germans. In chapter 5 I argue that differences in access to social networks result in unequal chances of socio-economic mobility in the receiving society: while many institutionally-funded migrants remain long-term unemployed, self-funded persons find their way into the labor market by means of ethnic entrepreneurship or with German employers. Beliefs about *kul'turnost* and 'taking life as it is' transform throughout migratory processes, being re-shaped by new living conditions and new social networks.

People who have adopted a pro-active, individualistic approach to health throughout their socialisation in the former USSR, reflect upon migration to Germany as a transition empowering them to continue taking care of themselves the way they believe to be healthy. In Chapter 5 I demonstrate how *kul'turnost* grows transformed into *westernisation*, with those, previously identifying themselves with high culture, willing to adopt new health beliefs and help-seeking practices they believe to be specific of the 'cultured' West. These persons distinguish strongly between the 'socialist' and the 'western' attitude to health, attributing them opposite characteristics. Whereas 'Soviet' life is associated in their accounts with unhealthy behaviours, such as poor nutrition, alcoholism, abuse of antibiotics, smoking and lack of exercise, the 'West' is cast as a place where people are making reflexive choices about what they eat, where they question the authority of bio-medical intervention, smoke and drink less, and altogether behave pro-actively with respect to promoting their health. Similar conceptualisations have been made by some former GDR interview participants: those persons who have a strong history of political dissent in their families spoke negatively of the East German approach to health. These folk conceptualisations seem to a great extent to mimic some scholarly discussions on socialist fatalism, historically being rooted in a same Cold War logic of anti-Soviet discourse. Indeed, 'westernised' migrants identify themselves in retrospect as non-conformists in Soviet society, pointing to their dissident political beliefs or ideologically

'wrong' consumerist practices. Migration is rationalised as an act of 'anti-socialist' behaviour, and the transformation of 'cultured' identity into a 'westernised' identity is a relatively smooth process. For these persons, achieving health means adopting individual behaviours attributed to West as inherent. Such westernisation is especially strongly expressed in self-funded migrants, who build their identity on their independent status and ability to 'make it' in the new society without institutional support. The pre-figurative families of migrants from the former privileged background are supportive in this identity transformation process. Believing that they have to learn from their children, these informants do not feel that success of the youngest generation and their rapid westernisation undermines their status and authority.

Those who internalized an understanding of health as a result of external circumstances, regard migration as a transition to a new life. The new 'world of plenty' has both positive and negative components, either understood as being out of the individual reach. The positive changes are conceptualised as the German 'grace', as mentioned in chapter 6, with such 'simple' things as reliable housing, safety of public spaces and accessibility of public transport are reflected upon with great admiration, gratitude and are considered to be strong determinants of better health. For many formerly disempowered persons migration meant the alleviation of the daily burden. Even those persons who need to draw on welfare benefits consider their material well-being much better than in the sending country. At the same time, unemployment and forced transformation of generation and gender roles are regarded as drawbacks of the capitalist society, destroying the stability of the extended post-figurative family and threatening health. Achieving or maintaining health is understood as keeping family structures intact and as being employed.

Migrants' perception of liberalised German healthcare provision, based on the idea of the autonomous, informed patient, also results from their experience in the sending country and their inclusion in specific migratory processes. Satisfaction or dissatisfaction is conceptualised through reflexive comparisons of experience 'there' and 'here'.

Persons most satisfied with care are the former disadvantaged, institutionally funded Russian Germans, on the one hand, and the self-funded migrants recruited from the group of privileged, on the other. For the former, the satisfaction with medical treatment they receive results from the availability of services and from commodities related to their utilisation unknown in the sending country: clean surgeries, smiling personnel and

equipped hospitals make up the core of satisfaction accounts. Healthcare is conceptualised as a positive part of new life, which is imposed on one. Russian German migrants from rural areas do not develop complex strategies of help-seeking, instead, they tend to rely on help of a limited number of medical professionals, mostly choosing them by geographical principle. In formerly privileged and presently upwardly mobile self-funded migrants, satisfaction, in contrast, results from the ability to exercise choice and be in charge of treatment. Unlike the formerly disadvantaged, the self-funded migrants develop complex help-seeking strategies which encompass both bio-medical and non-biomedical treatment. They get access to practitioners through their weak ties across different cohorts of migrants and networks of native Germans. For them, liberalized healthcare provision is an empowerment to practise *kul'turnost* by making reflexive choices. Help-seeking strategies, comparable in complexity to those of self-funded migrants, are observed across native German research participants socialised in the West: for them, the principle of free choice is also empowering and beneficial.

Persons least satisfied with German provision of healthcare are the institutionally funded, formerly fragmentarily empowered (first generation Russian German intelligentsia and skilled urban workers) and the ex-privileged (former Jewish intelligentsia). Both categories of migrants believe in individual responsibility for health and, as discussed above, were actively seeking help by those means available to them in their sending countries. Migration, however, has stripped them of their main source of empowerment: informal social networks in the medical profession and equality of status with health-care providers. The institutionally-funded former urban intelligentsia and the long term unemployed are reliant on the services of the migrant community, and are unable to develop strategies of access to healthcare, comparable to those they employed in their sending countries. Unlike the self-funded, they are unable to use informal connections and need to approach the system through institutional gatekeepers, and feel treated impersonally. Mechanisms of personalization, such as informal exchange or payments, lose their relevance in a comparatively well-funded insurance-based system. The dissatisfaction with 'impersonal' treatment also results from the fact that migrants in these groups tend to seek help from Russian-speaking practitioners, who are often immigrants themselves, but are unequally high in status. The identity boundaries created by successfully employed self-funded doctors may feel stigmatizing to long-term unemployed institutionally-funded patients, forced to seek 'Russian' medical help through a lack of proficiency in German. At the same time, the dependence on medical expertise increases,

as migrants with poor knowledge of German and only a few connections outside of their own cohort, experience difficulties seeking help elsewhere. Seeking 'control', these migrants find what they believe to be impersonal treatment, with decision-making being their responsibility. Choice is conceptualised as an immoral concept in their accounts of help-seeking.

In Chapter 8 I demonstrate that two aspects of healthcare provision are, however, praised across all groups of migrants: hospital treatments and nursing care. These two ways of providing medical help are conceptualised as most legitimate, inasmuch they replicate traditional structures of relationships between experts migrants have socialised with.

The satisfaction with hospital treatment was a striking contrast to the dissatisfaction with outpatient services in groups of institutionally-funded migrants. The hospital setting requires significantly less decision-making on the patient's part, instead, all treatment choices are apparently being made by those who are vested with power: the doctors. At the same time, in comparison to the sending country, the former privileged and fragmentarily empowered feel spared the necessity of arranging hospitalization by mobilizing their private networks in order to make a choice: migrants believe that all hospitals in Germany are equally well equipped and staffed. Only one case of hospitalization in the self-funded group was studied in this thesis, hence, it is not clear whether persons approving greatly of the choice principles in outpatient setting, would feel comfortable in a hospital. West Germans, a group which has demonstrated patterns of help-seeking behaviors most similar to self-funded migrants, were quite skeptical of the 'paternalism' practised in hospital treatment.

In Chapter 8 I demonstrate how the tradition of informal care provision becomes successfully combined with professional medical care, discussing ways nursing care is integrated in migrants' family. Unlike the case of outpatient services, migrants do not feel confronted with choices related to management of ambulant nursing. This smooth integration of biomedical expertise into family tradition is possible, because the authority of legitimate decision-makers, that is, women, is not challenged, as care providers follow their requests and structure their activities in accordance to needs of the family. Nursing care alleviates the burden of informal care, however, it does not challenge the distribution of generation and gender role in the family in principle. Instead, it provides with a desirable degree of autonomy.

In spite of great differences across the groups of migrants, who were socialised under different circumstances, and arrived in Germany as part of different migratory processes, there are at least two common features which mark all persons from the former USSR as different from Germans.

First, all migrants who were interviewed, regard the natural environment as being beyond an individual's control. In all interviews the natural environment is attributed to external conditions of life, which need to be taken as they are. In Chapter 6 I demonstrate that there is no comparably pro-active approach to nature, as there is among German interviewees. Whereas among persons with lower SES, there is no discrepancy between migrants and non-migrants, the difference is very pronounced in comparable groups with higher SES. Whereas the better-educated, employed Charlottenburg-based Germans conceptualise their own pursuit of health in terms of improving environmental conditions, migrants regard nature as imposed on them. In that respect the practices of eco-consumerism have very different meanings in native German and in migrant households: while Germans are trying to 'save the world' by collective action, migrants are 'westernizing' themselves having no other goals but the individualistic.

Second, in all multiple-person migrant households a strongly gendered division of labour in the provision of help and in beliefs about health is observed. Men are less likely to take a pro-active approach to health, whereas women constitute the executive power. Not only are migrant women much more strongly involved in controlling the health of other family members informally, they also organize access to healthcare and nursing services for them by accompanying others to their appointments, giving tasks to nursing care professionals and choosing healthcare providers. At the same time, all migrant women, regardless of SES, tend to choose the highest degree of medical intervention in issues related to pregnancy and birthing, which strikes a vivid contrast with native German women. In Chapter 8 I suggest that this reliance on medical care is a result of socialisation in a healthcare system which used to pathologize pregnancy and child birth and also an outcome of the unequal distribution of care-giving roles in families. Less able to seek help from their male partners, than German women, migrant women rely to a greater extent on medical experts.

Contribution to existing debate. Prospects for further research. Policy implications.

The findings of this thesis suggest prospects for further research and policy implications.

As the literature review suggests, at the moment little is known about health outcomes of migrants from the former USSR in Germany, given that they have been poorly covered by national public health and epidemiological surveys. It would be advisable to develop sampling strategies, permitting better inclusion of these people in further research. For example, municipal statistics on persons with *Migrationshintergrund* may be of some help for locating neighbourhoods densely populated by 'Russians', and for recruiting residents of these neighbourhoods.

Most important is that along with epidemiological research and public health interventions, socio-economic contexts of migrants' lives could be studied, and, perhaps, improved. As I have demonstrated in Chapter 5, the improvement of material living conditions, although reflected upon as positive by research participants, can not substitute for the collapse of social networks and family ties. The middle-aged generation of institutionally-funded Russian Germans is in a particularly precarious situation, suffering from long-term unemployment, leading to ruptures in kin relationships and to loneliness. Unlike Jewish migrants they have fewer resources for ethnic entrepreneurship, and do not have soft skills for self-employment (such as giving private lessons, for example). Unable to establish social networks beyond their immediate family or acquaintances from the transition camps, institutionally-funded migrants experience difficulties seeking help. Addressing unemployment in institutionally-funded migrants from the former USSR could include several policies.

First and foremost, a different approach to the recognition of foreign qualifications needs to be adopted by German employment officials at official Job Centres. Rather than following the checklist approach, ticking off years in education and formal positions occupied in the sending countries, it would be advisable to focus more on migrants' soft skills. German government sponsors re-training courses for the long-term unemployed, however, migrants are not motivated to take them due to poor language skills. Obligatory language courses many people had to take in their transitional camps were too unspecific and far too short. Hence, sponsored language courses need to be more occupation-specific, giving people confidence in their ability to apply their skills in a new country. Internships with local employers, supported and sponsored by governmental programs, could also contribute to migrants' understanding of the German labour market and to their inclusion into wider social networks. Professional re-training, however, may not resolve problems of low qualified Russian Germans with agricultural backgrounds. Projects supporting employment of these persons in local farming industry could be developed and evaluated.

Second, as the case of self-funded migrants demonstrates, ethnic entrepreneurship may play a positive role in supporting migrants' upward social mobility. A specific niche which could be supported by healthcare policy making is the development and support of Russian-speaking *Pflege* (nursing) services. As I discussed in Chapter 8, ambulant nursing care is utilized in many migrant families and often plays a role of a link to the 'outer' world. *Pflege* professionals not only do household work and provide minor medical help, by helping with filling in papers and translating in official settings, they also perform as network brokers between migrant families and the wider institutional setting they are embedded in. Besides, an increasing number of female migrants from the former USSR are being employed in this sector. At the moment, little is known about these services, the quality of their performance and the working conditions are hard to estimate. Further research could find out prospects for improvement and standardization of quality in 'Russian' nursing care services, and delineate ways in which they can be supported by policy measures.

Further research should investigate the effects of life in transition camps on migrants' networks and their social mobility. In Chapter 5 I discuss how such networks, emerging out of common experience, can be supportive, but may also lead to encapsulation in community of 'precarians' (to use Bauman's term discussed in Chapter 5), as they do not include ties to people who have not had the same experience of migration. Transition camps make up a crucial component of the institutionally-funded migration process. Given that Germany continues accepting and distributing new cohorts of migrants through the camp system, such research could investigate the costs and benefits of this practice.

And last but not least, research into socialist cultures in transition can provide insights into how identities are constructed and negotiated. The Russian Berlin is phenomenon which may offer particularly rich accounts of individual and collective transformation. In his historical research on 'Russian' Berlin of the 1920s, Karl Schlögel observes:

Russian Berlin was not just 'Russia in miniature' (...), with all possible social classes and status groups represented in it, it was also a reflection of common experience of post-Revolution collapse. It was a society of the 'former' people, of the 'ex', the notions immigrants themselves used to describe their situation. Most of them had to, at least for a short time, make a living by engaging in occupations and spheres previously unknown to them

Although Schlögel discusses those Russians who came to Berlin almost a century ago, his observation also holds true for people who live there now and who were studied in this thesis. As I have demonstrated in Chapters 3, 4 and 5, the latest migrant cohorts are marked by extreme heterogeneity, in terms of their background and cultural heritage, and in terms of their position in the receiving country alike. Similarly to 'White' émigrés, populating Charlottenburg in the 1920s, people who were interviewed in my research, also had to re-invent themselves in a new society. Whether they now live off social welfare or run a successful fashion retail business, they all make a living in ways they could not conceive of in their sending countries. Only a few were able to continue practising their profession or, in fact, to learn it in Germany. The experience of downward social mobility, in the 1920s embodied in a folklore figure of a former Moscow professor driving taxi, is all too familiar to people, whose lives I have discussed in my work. The common experience of 'collapse' Schlögel is discussing is also an integral part of the 'new' Russian Berlin. Like those early migrants of the 1920s, *Spätaussiedler*, *Kontingentflüchtlinge* and self-funded migrants have witnessed the disappearance of the country they grew up and socialised in, a country which, whether loved or hated, was theirs and, hence, defined their identities in a variety of ways. Like families of Petersburg writers, Moscow doctors, Jewish dressmakers and noble Russian German army officers many years ago, migrants I have spoken to were fleeing the uncertainty which was sweeping through their cities, towns and collective farms. From the moment they crossed the German border, their material uncertainties, perhaps, resolved themselves partially (unlike in case of the earliest migrants), whether taken care of by welfare state, or by existing migrant communities. However, the uncertainty of identity, the feeling of being a 'former' person, from then on became a feeling, dominating lives of many. A few, instead, took uncertainty as a chance for entrepreneurial risk and adventure, departing easily from their 'ex' selves. As Schlögel summarises:

The sociology of Russian Berlin would have to be the sociology of role transformation and personal metamorphosis (Schlögel 1998: 106).

Transformation and personal metamorphosis were at the core of this thesis, focused on the relationship of migratory process and health beliefs. It demonstrated that what we think about health is a part of who we are, socially, culturally and individually.

Embedded in our biography, our health beliefs change. And, finally, like all beliefs about self, health beliefs make up parts of invisible iron curtains we may erect towards other people or our own past.

Bibliography

- (2004) Daten und Fakten zur Bevölkerungs- und Sozialstruktur. G. Bezirksamt Charlottenburg-Wilmersdorf. Abteilung Soziales, Umwelt und Verkehr. Bezirksamt Charlottenburg-Wilmersdorf, Berlin.
- (2005) Immigration Law and Policy. Federal Ministry of Interior.
- (2008). Kinder- und Jugendgesundheitssurvey (KiGGS) 2003–2006: Kinder und Jugendlichen mit Migrationshintergrund in Deutschland. Beiträge zur Gesundheitsberichterstattung des Bundes. Berlin, Robert Koch Institut.
- (2008) Leitbild. Lokale Agenda 21: Charlottenburg-Wilmersdorf. Bezirksamt Charlottenburg-Wilmersdorf, Berlin.
- (2008) Schwerpunktbericht: Migration und Gesundheit. Gesundheitsberichterstattung des Bundes, Robert Koch Institut.
- (2008) Sozialstrukturatlas Berlin 2008. Senatverwaltung für Gesundheit, Umwelt und Verbraucherschutz. Berlin.
- (2010) 8. Bericht der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration über die Lage der Ausländerinnen und Ausländer in Deutschland. Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration. Berlin.
- (2010) Sechster Bericht zur Lage der älteren Generation in der Bundesrepublik Deutschland. Altersbilder in der Gesellschaft. Bundesministerium für Familien, Senioren, Frauen und Jugend. Berlin.
- (2011) Demographische Situation in Marzahn-Hellersdorf 2010. Bezirksamt Marzahn-Hellersdorf von Berlin, Abteilung Gesundheit, Soziales und Personal Plan- und Leitstelle Gesundheit und Soziales. Berlin.
- Abbott, P., Turmov, S., Wallace, C. (2006). "Health world views of post-soviet citizens." Social Science and Medicine **62** (1): 228-238.
- Ahmad, W., Bradby, H., (2007). "Locating ethnicity and health: exploring concepts and contexts." Sociology of Health and Illness **29**(6): 795–810.
- Alexievich, S. (2005). Voices from Chernobyl: The Oral History of a Nuclear Disaster, Dalkey Archive Press
- Allen, R. (Ed.) (1990) The Concise Oxford Dictionary of Current English, 8th Edition. Oxford, Clarendon Press.
- Andreev, E., Nolte, E. et al. (2003). "The evolving pattern of avoidable mortality in Russia." International Journal of Epidemiology **32**: 437–446.
- Aroian, K., Khatutsky, G., Tran, T., Balsam, A. (2004). "Health and Social Service Utilisation Among Elderly Immigrants from the Former Soviet Union." Journal of Nursing Scholarship **33**(3): 265 - 271.
- Augé, M. and C. Herzlich (1995). The meaning of illness: anthropology, history and sociology. Luxembourg; Philadelphia, Harwood Academic Publishers.
- Balabanova, D., Falkingham, J. et al. (2003). "Winners and Losers: Expansion of Insurance Coverage in Russia in 1990s." American Journal of Public Health **93**: 2124–2130.
- Baker, S., Thompson, K. et al. (2004) "Mapping the values driving organic food choice: Germany vs the UK", European Journal of Marketing, **38**(8): 995 - 1012
- Baraulina, T. (2003). "The State Construction of Reality: Social Consequences of the Migration Policies (Государственное конструирование реальности: социальные последствия миграционной политики)." Рубеж (18): 65-110.
- Barth, F. (1969). Ethnic groups and boundaries. The social organisation of culture difference. Oslo, Universitetsforlaget.

- Becher, H., Razum, O. et al. (2007). "Mortality of Immigrants from the Former Soviet Union: Results of a Cohort Study." Deutsche Ärzteblatt **104**(23): 1655–1661.
- Becker, F. (2001). Ankommen in Deutschland. Einwanderungspolitik als biographische Erfahrung im Migrationprozess russischer Juden. Berlin, Dietrich Reimer Verlag.
- Benisovich, S., King, A. (2003). "Meaning and knowledge of health among older adult immigrants from Russia: a phenomenological study." Health Education Research **18** (2): 135-144.
- Berkman, L. (1984). "Assessing the Physical Health Effects of Social Networks and Social Support." Annual Review of Public Health **5**: 413-432.
- Berkman, L. (2000). Social integration, social networks, social support, and health. Social Epidemiology. Berkman, L., Kawachi, I. (eds.), Oxford University Press.
- Beyer, M. (2001). Altersbilder und das Verständnis von Gesundheit im Alter aus der Sicht älterer russlanddeutscher Spätaussiedler. In: Zielke-Nadkarni, A., Schnepf, W. (Eds.) Pflege im kulturellen Kontext (pp. 69-70). Huber, Berlin.
- Biegel, D. E., Sales, E. et al. (1991). Family caregiving in chronic illness. London, Sage.
- Biloukha, O., Utermohlen, V. (2001). "Healthy eating in Ukraine: attitudes, barriers and information sources." Public Health Nutrition **4** (2): 207-215.
- Birbili, M. (2000). "Translating from one language to another." Social Research Update Winter.
- Blair, A. (1993). Social class and contextualization of illness experience. In: Radley, A. (Ed.) Worlds of Illness. Biographical and cultural perspectives on health and disease (pp. 27-48). Routledge.
- Blaxter, M. (1990). Health and lifestyles. London, Routledge.
- Bloor, M. and Horobin, G. (1975). Conflict and conflict resolutions in doctor/patient interactions. In: Cox, A., Mead, A. (Eds.) A Sociology of Medical Practice (pp. 271-310). London, Collier-McMillan.
- Borde, T. (2003). Sind Migrantinnen gut versorgt? Handlungsbedarf und strukturelle Lösungsansätze. AKF Tagung „Lust auf Dialog“. Berlin.
- Borde, T. and David, M. (2007). "[Treatment of immigrants in emergency clinics]." MMW Fortschritte der Medizin **149**(42): 38-39.
- Borde, T., David, M., Kantenich, H. (2002). "What Turkish-speaking women expect in a German hospital and how satisfied they are with health care during their stay in a gynaecological hospital in Berlin - a comparative approach." Gesundheitswesen **64** (8-9): 476-485.
- Borde, T., Dudenhausen, J. W. et al. (2008). "[Migrants in obstetrics--psychosomatic aspects in the context of acculturation]." Psychotherapie, Psychosomatik, Medizinische Psychologie **58**(3-4): 183-188.
- Boym, S. (1994). "The Archeology of Banality: The Soviet Home." Public Culture **6**(2): 263-292.
- Boym, S. (1994). Common places: Mythologies of everyday life in Russia, Harvard University Press.
- Bradby, H. (1997). Health, eating and heart attacks: Glaswegian Punjabi women's thinking about everyday food. In: Caplan, P. Food, Health and Identity (pp. 213-233). London, Routledge.
- Bradby, H. (2002). "Translating culture and language: a research note on multilingual settings." Sociology of Health and Illness **24**(6): 842–855.
- Bradby, H. (2003). "Describing ethnicity in health research." Ethnicity and health **8**(1): 5-13.
- Bradby, H. (2009). Medical sociology: an introduction. London, SAGE.
- Brettell, C. (1998). The City as Context: approaches to Immigrants and Cities. Metropolis International Workshop, Lisbon, Luso-American Development Foundation.
- Brown, J. and Rusinova, N. (1993). "Lichnie svyazi i kariera bolezni." Sociologicheskie

Issledovaniya (3): 30-36.

- Brown, J. and N. Rusinova (1997). "Russian medical care in the 1990s: A user's perspective." Social Science and Medicine 45(8): 1265-1276.
- Brown, J. and N. Rusinova (1999). "Socialnie neravenstva i zdorovie." Zhurnal sociologii i socialnoi antropologii 2(1).
- Brown, J. and N. Rusinova (2002). "'Curing and Crippling': Biomedical and Alternative Healing in Post-Soviet Russia." Annals of the American Academy of Social and Political Sciences (583): 161-170.
- Brown, J. and Rusinova, N. (2011). Socioeconomic Status and Health in St. Petersburg, Russia: Life Chances and Lifestyle Strategie. Conference paper: Health in transition: (Bio)Medicine as culture in post-socialist Europe. Prague.
- Brubaker, R. (1994). "Nationhood and the National Question in the Soviet Union and Post-Soviet Eurasia: An Institutional Account." Theory and Society (23): 47-78.
- Bryman, A. (2008) Social Research Methods (Third edition) Oxford: Oxford University Press.
- Burger, E., Field, M. et al. (1998). "From Assurance to Insurance in Russian Healthcare: The Problematic Transition." American Journal of Public Health 88(5): 755.
- Bury, M. (1982). "Chronic illness as biographical disruption." Sociology of Health and Illness 4(2): 167-182.
- Bush, H., Williams, R., Bradby H., Anderson, A., Lean, M. (1998). "Family Hospitality and Ethnic Tradition Among South Asian, Italian and General Population Women in the West of Scotland." Sociology of Health and Illness 20(3): 351-380.
- Byrne, B. (2004) Qualitative interviewing. In: Seale, C. (Ed.) Researching Society and Culture (pp.179-192), SAGE.
- Calnan, M. (1987). Health and illness : the lay perspective. London, Tavistock.
- Caplan, P. (1997) Food, health and identity. London, Routledge.
- Cattell, V. (2001). "Poor people, poor places, and poor health: the mediating role of social networks and social capital." Social Science and Medicine 52(10): 1501-1516.
- Clark, J. (2011). "More than a Photo: Germans from Russia Remember Their Familial Relationships." Journal of Family History 36: 333-349.
- Clarke, S. (2002). Making ends meet in contemporary Russia : secondary employment, subsidiary agriculture and social networks. Cheltenham, Edward Elgar.
- Cockerham, W. (1997). "The Social Determinants of the Decline of Life Expectancy in Russia and Eastern Europe: A Lifestyle Explanation." Journal of Health and Social Behavior 38(2): 117-130.
- Cockerham, W. (1999). Health and social change in Russia and eastern Europe. NY, Routledge.
- Cockerham, W., Snead, C., DeWaal, F. (2002). "Health Lifestyles in Russia and Socialist Heritage." Journal of Health and Social Behavior 43(1): 42-55.
- Cockerham, W. C. (2000). "Health lifestyles in Russia." Social Sciences and Medicine 51 (9): 1313-1324.
- Cohen, A. (1974). Urban ethnicity, London.
- Cohn-Bendit, D., Schmid, T. (1993). Heimat Babylon. Das Wagnis der multikulturellen Demokratie. Hamburg, Campe Paperback.
- Conrad, P. (1992). "Medicalization and Control." Annual Review of Sociology 18: 209-232.
- Conrad, P. (2007). The medicalization of society : on the transformation of human conditions into treatable disorders. Baltimore, Md. ; London, Johns Hopkins University Press.
- Conrad, P., Schneider, J. (1980). Deviance and Medicalization: From Badness to Sickness. St. Louis, Mosby.
- Corbin, J. M. and A. L. Strauss (1988). Unending work and care : managing chronic illness at home. San Francisco, Jossey-Bass Publishers.

- Cornwell, J. (1984). Hard Earned Lives, London, Tavistock.
- Cortes, K. (2004) Are Refugees Different from Economic Immigrants? Some Empirical Evidence on the Heterogeneity of Immigrant Groups in the United States. The Review of Economics and Statistics, **86**:(2): 465-480
- Courtenay, W. (2000). "Constructions of masculinity and their influence on men's well-being: a theory of gender and health." Social Science and Medicine **50**: 1385-1400.
- Damelang, A. (2011). Arbeitsmarktintegration von Migranten. Die Potenziale kultureller Vielfalt nutzen. IAB Bibliothek, Institut für Arbeitsforschung, Berlin.
- Darieva, T. and Schütte, G. (1997). Eksurs: "Evropacenter - Eine Zeitung in Berlin - oder "Russischsprechende alle Nationalitäten, vereinigt euch!". In: Oswald, I. and Voronkov, V. (Eds.) Post-sowjetische Ethnizitäten. Ethnische Gemeinden in St. Petersburg und Berlin/Potsdam (pp.213-220). Berliner Debatte Wissenschaftsverlag.
- David, M. and Borde, T. (2002). "[Nursing care for immigrants: ethnic-cultural aspects in maternity care]." Pflege Zeitschrift **55**(1): 21-24.
- David, M., Borde, T., Kentenich, H. (2000). "Knowledge among German and Turkish Women about Specifically Female Bodily Functions, Contraception, Preventative Medical Examinations and Menopause." Ethnicity and Health **5**(2): 101-112.
- David, M., Borde, T., Kentenich, H. (2002). "Ist die Hyperemesis gravidarum heute vor allem eine Erkrankung von Migrantinnen?" Geburtshilfe und Frauenheilkunde **62**(4): 327-332.
- David, M., Schwartau, I. et al. (2006). "Emergency outpatient services in the city of Berlin: Factors for appropriate use and predictors for hospital admission." European Journal of Emergency Medicine **13**(6): 352-357.
- Dembon, G. (1994). Fremde Deutsche in deutscher Fremde : Integrationsprobleme von Aussiedlern im kommunalen Raum. Regensburg, Roderer Verlag.
- Diefenbach, H., Weiß, A. (2006). "Zur Problematik der Messung von "Migrationshintergrund". " Münchener Statistik (3).
- Dietz, B. (1995). Zwischen Anpassung und Autonomie : Russlanddeutsche in der vormaligen Sowjetunion und in der Bundesrepublik Deutschland, Duncker & Humblot.
- Dietz, B. (1999). Ethnic German Immigration from Eastern Europe and former Soviet Union: The Effect of Migrant Networks. Institut zur Zukunft der Arbeit (IZA): Discussion paper. IZA. Bonn.
- Dietz, B. and Hilkes, P. (1992). Russlanddeutsche: Unbekannte im Osten: Geschichte, Situation, Zukunftsperspektiven, Olzog Verlag.
- Dietz, B., Lebok, U. et al. (2002). "The Jewish Emigration from the Former Soviet Union to Germany." International Migration **40**(2): 29-48.
- Dodds, D. (1998). "Five years after unification: East German women in transition." Women's Studies International Forum **21**(2): 175-182.
- Doomernik, J. (1997). Going West: Soviet Jewish Immigrants in Berlin since 1990, Edward Elgar.
- Doyal, L. (1995). What makes women sick. Gender and the political economy of health. London, Macmillan.
- Dreißig, V. (2005). Interkulturelle Kommunikation im Krankenhaus. Eine Studie zur Interaktion zwischen Klinikpersonal und Patienten mit Migrationshintergrund, Forum: Qualitative Social Research.
- Economist (2008). Immigrants from the former Soviet Union are transforming Jewish life in Germany. The Economist, <http://www.economist.com/node/10424406> (last access 21.03.2012)
- Eisfeld, A. (1999). Die Russlanddeutschen. Muenchen, Langen Mueller.
- Engelkemier, J. M. (2001). A study in identity : ethnic Germans from the CIS "returning" to

Germany. Coe College.

- Eyselein, C. (2006). Rußlanddeutsche Aussiedler verstehen. Praktisch-theologische Zugänge. Leipzig, Evangelische Verlagsanstalt.
- Faltins, R. (2010) Bio-Lebensmittel in Deutschland: Kaufbarrieren und Vermarktung. Hamburg, Diplomica.
- Fassmann, H. and Münz, R. (1994). "European east-west migration, 1945-1999." International Migration Review 28(3): 520-553.
- Field, M. (1988). "The Position of the Soviet Physician: The Bureaucratic Professional." The Milbank Quarterly Vol. 66, Supplement 2: **The Changing Character of the Medical Profession**: 182-201.
- Field, M. G. (1957). Doctor and Patient in Soviet Russia, Harvard University Press: Cambridge.
- Field, M. G. (1967). Soviet socialised medicine: an introduction, Free Press.
- Field, M. G. (1987). Medical Care in the Soviet Union: Promises and Realities. In: Herlemann, H. (Ed.) Quality of life in the Soviet Union. Boulder, Colo., Westview Press.
- Field, M. G. (1989). Success and crisis in national health systems : a comparative approach. London, Routledge.
- Field, M. G. (1995). "The health Crisis in the Former Soviet Union: A Report from the "Post-War" Zone." Social Science and Medicine 41(11): 1469-1478.
- Field, M. G. and Twigg, J. L. (Eds.) (2000). Russia's torn safety nets : health and social welfare during the transition. Basingstoke, Macmillan.
- Fischer, M. (2008). Das Konzept des Migrationshintergrundes im Mikrozensus und öffentlichen Diskurs. Hamburg Institute of International Economics.
- Gans, H. (1992) „Second-generation decline: Scenarios for the economic and ethnic futures of the post-1965 American immigrants“. Racial and Ethnic Studies 15(2): 173-192.
- Garrett, L. (2001). Betrayal of Trust. The Collapse of Global Public Health. NY, Oxford University Press.
- Gartner, A., Riessman, F. (1984). The self-help revolution, Human Sciences Press.
- Gerasimova, K. (2003). Public privacy in the Soviet communal apartment. In: Crowley, D., Reid, S. (Eds.) Socialist spaces. Sites of everyday life in the eastern bloc (pp. 207-230). Berg Publishers.
- Gitelman, Z. (1997). From a northern country: Russian and Soviet Jewish immigration to America and Israel in historical perspective. In: Lewin-Epstein, N., Ro'i, Y., Ritterband, P. Russian Jews on Three Continents (pp. 21-41). London, Frank Cass.
- Gorelik, L. (2006). Meine weißen Nächte, Diana Verlag.
- Granovetter, M. (1973). "The Strength of Weak Ties." American Journal of Sociology 78(6): 1360-1380
- Graudenz, I. and Römhild, R. (1996). Forschungsfeld Aussiedler : Ansichten aus Deutschland. Frankfurt am Main, Lang.
- Green, G., Bradby, H., Chanc, A., Lee, M. (2006). ""We are not completely Westernised": Dual medical systems and pathways to health care among Chinese migrant women in England." Social Science and Medicine 62(6): 1498-1509.
- Gussow, Z. (1976). "The role of self-help clubs in adaptation to chronic illness and disability." Social Science and Medicine 10(7-8): 407-414.
- Hegner, V. (2008). Gelebte Selbstbilder. Gemeinden russisch-jüdischer Migranten in Chicago und Berlin. Frankfurt/New York, Campus.
- Heitman, S. (1987). The third Soviet emigration: Jewish, German and Armenian emigration from the USSR since World War II. Köln.
- Heusinger, J. (2008). Der Zusammenhang von Milieuzugehörigkeit,

- Selbstbestimmungschancen und Pflegeorganisation in häuslichen Pflegearrangements älterer Menschen. In: Bauer, U. and Büscher, A. (Eds.) Soziale Ungleichheit und Pflege. Beiträge sozialwissenschaftlich orientierter Pflegeforschung (pp. 301-314), VS Verlag für Sozialwissenschaften.
- Hickman, M. (1998). "Reconstructing deconstructing 'race': British political discourses about the Irish in Britain." Ethnic and Racial Studies 21(2): 288-307.
- Hilkes, P. and Kloos, H. (1988). Deutsche in der Sowjetunion : Sprachkompetenz und Sprachverhalten : Ergebnisse einer Befragungsstudie mit deutschen Spätaussiedlern aus der Sowjetunion. Osteuropa-Institut, München.
- Hinote, B., Cockerham, W., Abbott, P. (2009). "The specter of post-communism: Women and alcohol in eight post-Soviet years." Social Sciences and Medicine 68: 1254-1262.
- Holloway, L., Kneafsy, M. (Eds.) (2004). Geographies of rural cultures and societies. Ashgate.
- Härle, J. (2004). "Personen mit „Migrationshintergrund“ –ein neuer Begriff und seine Operationalisierung." Stadtforschung und Statistik 1: 16-18.
- Häussermann, H. and Kapphan, A. (2005). Berlin: From divided to fragmented city. In: Hamilton, I., Andrews, K., Pichler-Milanovic, N. (Eds.) Transformation of cities in Central and Eastern Europe: Towards globalization (pp. 189-222), United Nations University Press.
- James, W. P., Nelson, M. et al. (1997). "Socioeconomic determinants of health. The contribution of nutrition to inequalities in health." British Medical Journal 314(7093): 1545-1549.
- Jenkins, R. (1994). "Rethinking ethnicity: identity, categorization and power." Ethnic and racial studies 17(2): 197-223.
- Jenkins, R. (2008). Social identity. London, Routledge.
- Joppke, C. (2001). "Multicultural citizenship: a critique." Archive of european sociology XLII (2): 431-447.
- Kaminer, W. (2002). Russendisko, Manhattan-Goldmann.
- Kaminer, W. (2006). Küche totalitär. Das Kochbuch des Sozialismus von Wladimir und Olga Kaminer, Manhattan-Goldmann.
- Kapphan, A. (1997). Zuwanderung, Arbeitsmarkt und ethnische Gewerbe. Selbstständige Gewerbetreibende aus der ehemaligen Sowjetunion in Berlin. In: Oswald, I. and Voronkov, V. (Eds.) Post-sowjetische Ethnizitäten. Ethnische Gemeinden in St. Petersburg und Berlin/Potsdam (pp. 189-212), Berliner Debatte Wissenschaftsverlag, Berlin.
- Kay, R. (2011). Social security, care and the "withdrawing state" in rural Russia. In: Jäppinen, M., Kulmala, M., Saarinen, A. (Eds.) Gazing at Welfare. Gender and Agency in Post-socialist Countries. Newcastle upon Tyne, Cambridge Scholars: 145-168.
- Kessler, J. (2003) "Jüdische Migration aus der ehemaligen Sowjetunion seit 1990." HaGalil, <http://www.berlin-judentum.de/gemeinde/migration.htm> (last access 21.03.2012)
- Kleinman, A. (1980). Patients and Healers in the Context of Culture. Berkeley and Los Angeles, University of California Press.
- Kleinman, A. (1988). The illness narratives : suffering, healing, and the human condition, Basic Books.
- Klusmeyer, D. (1993). "Aliens, Immigrants, and Citizens: The Politics of Inclusion in the Federal Republic of Germany." Daedalus 122(3): 81-114.
- Knaus, W. A. (1981). Inside Russian Medicine. New York, Everest House.
- Konietzka, D., Kreyenfeld, M. (2001). "Die Verwertbarkeit ausländischer Ausbildungsabschlüsse. Das Beispiel der Aussiedler auf dem deutschen

Arbeitsmarkt." Zeitschrift für Soziologie 30: 267-282.

Korenblum, W., Bornstein, S., Fischer, S. (2010) Erkrankungen bei Migranten - Jüdische Kontingentflüchtlinge und deutsche Spätaussiedler aus der ehemaligen Sowjetunion. Diabetes aktuell, 8(1): 38-43

Kurthen, H. (1995). "Germany at the Crossroads: National Identity and the Challenges of Immigration." International Migration Review 29(4): 914-938.

Kyobutungi, C., Ronellenfisch, U. et al. (2006). "Mortality from external causes among ethnic German immigrants from former Soviet Union countries, in Germany." European Journal of Public Health 16(4): 376-382.

Kümpers, S. (2008). Alter und gesundheitliche Ungleichheit: Ausgangspunkte für sozialraumbezogene Primärprävention. Veröffentlichungsreihe der Forschungsgruppe Public Health. Schwerpunkt Bildung, Arbeit und Lebenschancen. Berlin, Wissenschaftszentrum Berlin für Sozialforschung (WZB).

Lammert, N. (2006). Verfassung. Patriotismus. Leitkultur. Was unsere Gesellschaft zusammenhält, Hoffmann und Campe.

Larkin, P. (2007). "Multilingual Translation Issues in Qualitative Research Reflections on a Metaphorical Process." Qualitative Health Research 17(4): 468-476.

Ledeneva, A. (1998). Russia's economy of favours : blat, networking, and informal exchanges. New York, Cambridge University Press.

Ledeneva, A. V. (2006). How Russia really works : the informal practices that shaped post-Soviet politics and business. Ithaca, Cornell University Press.

Leshem, E., Rosenbaum, Y. et al. (1989). Drop-outs and immigrants from the Soviet Union. In: Horowitz, T. (Ed.) The Soviet Man in an Open Society (pp. 57-63). New York and London, University Press of America

Levin, L., Katz, A., Holst, E. (1976). Self-care: lay initiatives in health. New York, Prodist, 1979.

Lindquist, G. (2002). "Healing efficacy and the construction of charisma: a family's journey through the multiple medical field in Russia." Anthropology & Medicine 9(3): 337-358.

Lindquist, G. (2006). Conjuring Hope: Healing and Magic in Contemporary Russia. New York, Oxford, Berghahn Books.

Lonkila, M. (1999). Social Networks in Post-Soviet Russia. Continuity and Change in the Everyday Life of St. Petersburg Teachers. Helsinki, Kikimora Publications.

Lupton, D. (2001) Food and the concept of risk: an Australian perspective. Sociology of Health and Illness, 27 (4): 468-467

Lüschen, G., Geling, O. et al. (1997). "After unification: Gender and subjective health status in East and West Germany." Social Science and Medicine 44(9): 1313-1323.

Lüschen, G., Niemann, S. et al. (1997). "The integration of two health systems: Social stratification, work and health in East and West Germany." Social Science and Medicine 44(6): 883-899.

Macintyre, S., Ellaway, A. et al. (2002). "Place effects on health: how can we conceptualise, operationalise and measure them?" Social Sciences and Medicine 55(1): 125-139.

McKee, M., Healy, J. et al. (Eds). (2002). Health care in central Asia. European Observatory on Health Care Systems Serie Buckingham and Philadelphia, Open University Press.

Mead, M. (1970). Culture and commitment: a study of the generation gap. New York, Garden City.

Meng, K. (2001). Russlanddeutsche Sprachbiografien: Untersuchungen zur sprachlichen Integration der Aussiedlerfamilien, Gunter Narr Verlag.

Mol, A. (2008). The logic of care : health and the problem of patient choice. London, Routledge.

- Nazroo, J. (1998). "Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health." Sociology of Health and Illness 20(5): 710–730
- Neidhart, C. (2002). Russia's carnival: the smells, sights, and sounds of transition, Rowman & Littlefield.
- Nettleton, S. (2006). The sociology of health and illness. Cambridge, Polity.
- Noelle-Neumann, E. (1991). "The German revolution. The historic experiment of the division and unification of a nation as reflected in survey research findings." International Journal of Public Opinion Research 3(3): 238-259.
- Novak, M. (1996). Unmeltable ethnics : politics & culture in American life. New Brunswick, Transaction.
- Ostendorf, H. (2007). Kriminalität der Spätaussiedler--Bedrohung oder Mythos? : Abschlussbericht einer interdisziplinären Forschungsgruppe. Baden-Baden, Nomos.
- Overing, J. (1987). Translation as a creative process: The power of the name. In: Holy, L. (Ed.): Comparative anthropology (pp. 70-87). Oxford, Basil Blackwell.
- Panova, L. and Rusinova, N. (2005). "Neravenstva v dostupe k pervichnoi medicinskoj pomoschi." Sociologicheskie Issledovaniia (6): 127-136.
- Petryna, A. (2002). Life Exposed: Biological Citizens after Chernobyl, Princeton University Press.
- Pietilä, I., Rytönen M. (2007). "Coping with stress and by stress: Russian men and women talking about transition, stress and health." Social Science and Medicine 66 (2): 327-338.
- Pietilä, I., Rytönen M. (2008). "'Health is a not a man's domain'. Lay accounts on gender difference in life-expectancy in Russia." Sociology of Health and Illness 30(7).
- Pinkus, B. (1988). The Jews of the Soviet Union: The History of a National Minority. Cambridge, Cambridge University Press.
- Pryor, F. (2005). "After Unification: Conversations with East Germans." Orbis 49(3): 491-502.
- Reiser, A. (2002). Vosvraschenie Odisseyi, Robert Burau Verlag.
- Remennick, L. (1999). "Preventive behavior among recent immigrants: Russian-speaking women and cancer screening in Israel." Social Science and Medicine 48(11): 1669-1684.
- Remennick, L. (2001). "'All my life is one big nursing home': Russian immigrant women in israel speak about double caregiver stress." Women's Studies International Forum 24(6): 685-700.
- Remennick, L. (2003). "'I Have No Time for Potential Troubles': Russian Immigrant Women and Breast Cancer Screening in Israel." Journal of Immigrant Health 5(4): 153-163.
- Rivkin-Fish, M. (1997). Reproducing Russia: women's health and moral education in the construction of a post-Soviet society. Princeton University Press.
- Rivkin-Fish, M. (2005). Women's health in post-Soviet Russia : the politics of intervention. Bloomington, Indiana University Press.
- Roesler, K. (2003). Russlanddeutsche Identitäten zwischen Herkunft und Ankunft : eine Studie zur Förderungs- und Integrationspolitik des Bundes. Frankfurt am Main, New York, P. Lang.
- Ronellenfisch, U., Kyobutungi, C. et al. (2006). "All-cause and Cardiovascular mortality among ethnic German immigrants from the Former Soviet Union: a cohort study." BMC Public Health 6(16).
- Ronellenfisch, U. and Razum, O. (2004). "Deteriorating health satisfaction among immigrants from Eastern Europe to Germany." International Journal for Equity in Health 3(1): 4.
- Rose, R. (2000). "How much does social capital add to individual health? A survey study of Russians." Social Science and Medicine (51): 1421-1435.

- Rose, R. (2003). Social Shocks, Social Confidence and Health. In: Twigg, J. and Schechter, K. (Eds.) Social Capital and Social Cohesion in Post-Soviet Russia (pp. 98-117). NY, M.E. Sharp.
- Rusinova, N. and Brown, J. (2003). "Social Inequality and Strategies for Getting Medical Care in Post-Soviet Russia." Health 7(1): 51-71.
- Sargent, H. (2005). Diasporic Citizens. Germans Abroad in the Framing of German Citizenship Law. In: O'Donnel, K., Bridenthal, R., Reagin, N. (Eds.) The Heimat Abroad. The Boundaries of Germanness (pp. 17-39). Ann Arbor, The University of Michigan Press.
- Schechter, K. (1991). "Soviet Socialised Medicine and the Right to Health Care in a Changing Soviet Union." Human Rights Quarterly 14(2): 206-215.
- Schechter, K. (1997). Physicians and Healthcare in the Former Soviet Union. In: Bernstein, J., Shuval, J. (Eds.) Former Soviet Doctors in Israel, Canada and the United States (pp. 29-40). Praeger: Westport.
- Schenk, L., Ellert, U., Neuhauser, H. (2007). "Kinder und Jugendliche mit Migrationshintergrund in Deutschland." Bundesgesundheitsblatt 50(5-6): 590-599.
- Schenk, L., Neuhauser, H. (2005). "Methodische Standards für eine migrantensensible Forschung in der Epidemiologie." Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz 48(3): 279-286.
- Schlögel, K. (1994). (Ed.) Der große Exodus. Die russische Emigration und ihre Zentren 1917 bis 1941. München, Beck.
- Schlögel, K. (1998). Berlin. Ostbahnhof Europas. Russen und Deutschen in ihrem Jahrhundert. Berlin, Siedler.
- Schnepp, W. (2002). Familiäre Sorge in der Gruppe der russlanddeutschen Spätaussiedler. Huber.
- Schoeps, J. (1996). Russische Juden in Deutschland, Beltz Athenäum.
- Schoeps, J., Jasper, W., Vogt, B. (1996). Russische Juden in Deutschland. Integration und Selbstbehauptung in einem fremdem Land. Weinheim, Beltz Athenäum.
- Schoeps, J., Jasper, W., Vogt, B. (1999). Ein neues Judentum in Deutschland. Fremd- und Eigenbilder der russisch-jüdischer Einwanderer. Potsdam, Verlag für Berlin-Brandenburg.
- Schrijvers, C., Dike van de Mheen, H., Stronks, K., Mackenbach, J. (1998). "Socioeconomic inequalities in health in the working population: the contribution of working conditions." International Journal of Epidemiology 27(6): 1011-1018.
- Schwarz, S. (1951). The Jews in the Soviet Union, Syracuse University Press.
- Shilova, L. (1999). Problemy transformatsii sotsial'noi politiki i individual'nykh orientatsii po okhrane zdorov'ia. Sotsial'nye konflikty: ekspertiza, prognozirovaniye, tekhnologii razresheniia. Moscow, Institut sotsiologii RAN.
- Shilova, L. (2002). "Transformatsiia zhenskoi modeli samosokhranitel'nogo povedeniia " Sociologicheskie Issledovaniya 11: 134-144.
- Shilova, L. (2005). Transformatsii samosokhranitel'nykh modelei povedeniia naseleniia v usloviakh reformiruemogo zdravookhraneniia. Conference paper: Health in transforming society: Discourse, politics and everyday life in modern Russia. Centre For Independent Social Research, St. Petersburg.
- Shkolnikov, V., Cornia, G. et al. (1998). "Causes of the Russian mortality crisis: Evidence and interpretations." World Development 26(11): 1995-2011.
- Shkolnikov, V., Leon, D. et al. (1998). "Educational level and adult mortality in Russia: An analysis of routine data 1979 to 1994." Social Science and Medicine 47(3): 357-369.
- Shkolnikov, V., M. McKee, et al. (2001). "Changes in life expectancy in Russia in the mid-1990s." Lancet 357(March 24): 917-921.
- Shkolnikov, V. M., Andreev, E. M. et al. (2004). "The peculiar pattern of mortality of Jews in

- Moscow, 1993-95." Population Studies (Cambridge) 58(3): 311-329.
- Shlapentokh, V. (1984). Love, marriage, and friendship in the Soviet Union : ideals and practices. New York, Praeger.
- Shlapentokh, V. (1989). Public and private life of the Soviet people : changing values in post-Stalin Russia. New York, Oxford University Press.
- Shtern, L. (2001). Leaving Leningrad. Hanover and London, Brandeis University Press.
- Siegrist, J., Knesebeck, O. et al. (2005). "Die Bedeutung des Faches Medizinische Soziologie für Lehre und Forschung an Medizinischen Fakultäten in Deutschland " Gesundheitswesen 67(4): 112-114
- Snyder, T. (2011) Bloodlands: Europe between Hitler and Stalin. Random House
- Sommer, T. (1998). Der Kopf zählt, nicht das Tuch - Ausländer in Deutschland: Integration kann keine Einbahnstraße sein. Zeit. 30.
- Staniewicz, T. (2001). Ethnicity maintenance : its contingent nature and impact on health : case studies of second generation Poles in the West Midlands (UK) and South Michigan. PhD Thesis, University of Warwick.
- Steptoe, A., Wardle, J. (2001). "Health behaviour, risk awareness and emotional well-being in students from Eastern Europe and Western Europe." Social Science and Medicine 53: 1621-1630.
- Temkina, A. (2008). "Patients in *Contemporary Russian* Reproductive Health Care Institutions: Strategies of Establishing Trust." Democratizatsiya 16(3).
- Temple, B. (1997). "Watch your tongue: issues in translation and cross-cultural research." Sociology 31: 607-618.
- Temple, B., Edwards, R. (2002). "Interpreters/Translators and Cross-Language Research: Reflexivity and Border Crossings." International Journal of Qualitative Methods 1(2).
- Thiel, C., Heinemann, L. (1996). "Nutritional behaviour differences in Germany." Reviews on environmental health 11(1-2): 35-40.
- Tibi, B. (2001). "Leitkultur als Wertekonsens - Bilanz einer missglückten deutschen Debatte." Aus Politik und Zeitgeschichte B(1-2): 23-26.
- Tishkov, V. (1997). Ethnicity, nationalism and conflict in and after the Soviet Union, SAGE.
- Twigg, J. (1998). "Balancing the State and the Market: Russia's adoption of Obligatory Medical Insurance." Europe-Asia Studies 50(4): 583-602.
- Vasta, E. (2004). Informal Employment and Immigrant Networks: A Review Paper. Centre on Migration, Policy and Society.
- Vertovec, S. (2007). "Super-diversity and its implications." Ethnic and Racial Studies 30(6): 1024-1054.
- Wacquant, L. (2008). Urban outcasts : a comparative sociology of advanced marginality. Cambridge, Polity.
- Walter, B. M., Hickman, M. J. et al. (2002). The second-generation Irish : a hidden population in multi-ethnic Britain. Swindon, Economic and Social Research Council.
- Weber, M. (1964). The theory of social and economic organisation. Simon and Shuster.
- Whorf, B. L. (1956). Language, thought, and reality: selected writings. Cambridge, Technology Press of Massachusetts Institute of Technology.
- Werbner, P. (1990) The migration process: capital, gifts, and offerings among British Pakistanis. Oxford: Berg Publishers.
- Wierling, D. (2004). Heimat finden. Hamburg, Edition-Körper Stiftung.
- Wilkinson, R. G. (1996). Unhealthy societies : the afflictions of inequality. London ; New York, Routledge.
- Williams, G. (1993). Chronic illness and the pursuit of virtue in everyday life. In: Radley, A. (Ed.) Worlds of illness. Biographical and cultural perspectives on health and illness (pp. 92-108). Routledge.
- Williams, G. (2003). "The determinants of health: structure, context and agency." Sociology of Health and Illness 25(Silver Anniversary Issue): 131-154.

Wittig, U., Merbach, M., Siefen, R.G., Brähler, E. (2004). "Beschwerden und Inanspruchnahme des Gesundheitswesens von Spätaussiedlern bei Einreise nach Deutschland." Gesundheitswesen **66**: 85-92.

Appendix 1. List of Interview Participants

*Age, occupation and family state of interviewee is given as at the time of interview

** Only pseudonyms are used through the text, to protect interviewees' identities

I. Marzahn

Migrants:

1. Marina (45) and Petr (46) Diener

Russian German *Spätaussiedler*, arrived from rural Kazakhstan. In Germany since 2005, in Berlin since 2009. Both spouses have higher education, but are long-term unemployed and welfare dependent. Occupy a flat on a rather remote rim of Marzahn. Marina and Petr have two adult children (both receiving vocational education at the time of the interview). There is no known history of chronic or debilitating illness in the family.

Marina and Petr were recruited through Marzahn Quartiersmanagement.

2. Galina (38) and Sergey (41) Kaiser

Russian German *Spätaussiedler*, arrived from mid-sized Kazach industrial town. In Berlin since 1995. Both spouses have higher education and are involved in different forms of ethnic entrepreneurship: Galina is in charge of a Russian educational theatre project; Sergey runs a small cargo taxi business. The family occupies a newly built private house in a 'upper-end' residential end of Marzahn. Kaisers have four children, aged (at the time of interview) five months to sixteen years old. There is no known history of chronic or debilitating illness in the nuclear family, however, Sergey's sister is severely disabled and needs permanent care. Her condition served as one of the push factors for the extended family to leave.

Galina and Sergey were recruited with the personal assistance of Vadim (see below).

3. Larissa (65) and Mikhail (71) Meerswalder

Russian German *Spätaussiedler*, arrived from a mid-sized Ukrainian industrial town. In

Berlin since 2001. Mikhail is a professional military man, with an education level equal to a university degree. Larissa is a qualified clerk. During World War Two Mikhail, then a child, was brought to Bavaria with his mother by the German troops who brought ethnic Germans 'back home'. There they met the end of the war and then were forcibly transported back to the USSR. The rest of his family died in deportations and the Labour Army. Larissa is an ethnic Ukrainian, and have not suffered from discrimination at the hands of Russian Germans directly. They have a daughter and a son, both live in Berlin in the vicinity, together with grandchildren. Other members of the extended family also live close by. Larissa and Mikhail receive a pension, paid by the German state and occupy a two-room apartment in the very centre of Marzahn. Mikhail has a history of diabetes, very poorly treated in the Ukraine and related to multiple complications. Larissa is his main informal care provider.

Larissa and Mikhail were recruited with the assistance of a Russian German NGO consultancy run by Vadim.

4. Emma Lenz (75)

Russian German *Spätaussiedler*, arrived from mid-sized Kasakh industrial town; has higher education. In Berlin since 2004, receives a pension. Has one son, whose family migrated along her and broke up soon after arrival to Germany. Emma lives alone in a two-room flat in the centre of Marzahn. Her son lives nearby and visits regularly. Emma reports episodes of domestic violence related, in her words, to her son's alcohol abuse and long-term unemployment. In spite of these episodes, Emma considers herself to be in a very good shape health-wise.

Emma was recruited through Marzahn Quartiersmanagement.

5. Ludmila Kohl (45)

Russian German *Spätaussiedler*, arrived from rural Russia; has higher education. In Berlin since 2004. Is married (husband not interviewed) and has two adult children, living separately (in a close vicinity), both studying. Her whole extended family lives in Berlin, too. Neither Ludmila, nor her husband are employed, both reliant on welfare benefits. The family lives on the less migrant-populated rim of Marzahn, in a large three-room apartment. Ludmila has had a severe car accident within a few months of arrival in Germany, and has experienced several degrees of physical disability since then, resulting

in her need for permanent care and assistance, mostly undertaken by members of the extended family.

Ludmila was recruited through Marzahn Quartiersmanagement.

6. Albert (71) and Nina (71) Kranz

Russian German *Spätaussiedler*, arrived from rural Kazakhstan. Qualified (Albert) and unqualified (Nina) manual workers. In Berlin since 2000; receive a pension. Have three children, all of whom live in Berlin in close vicinity. Other members of the extended family also live in Germany or in Berlin, having arrived recently. Albert and Nina occupy a two-room apartment. At the time of interview Albert was suffering from a poorly healing broken hand, otherwise the spouses have not spoken of any long-term or chronic conditions in the family.

Albert and Nina were recruited through Marzahn Quartiersmanagement.

7. Irma Mauch (82)

Russian German *Spätaussiedler*, arrived from rural Kazakhstan. Has unfinished middle-school education, which was interrupted by World War Two. In the course of the war Irma was first forcibly transported to Germany by the Nazi troops, and in 1946 was sent back to the USSR, where she was placed in a labour camp. Due to dangerous working conditions there, Irma lost three fingers on the left hand. In the 1960s she moved to Kazakhstan, where she took a job as hospital nurse and then of a canteen cleaner. In Berlin since 2000; receives a pension. Irma migrated with her husband and three children, all of whom live in Berlin in close vicinity. Her husband, however, passed away soon after arriving in Germany. One of her sons is drinking heavily and served a sentence for manslaughter. An episode of domestic violence between him and his elderly mother occurred in the course of fieldwork, as he broke into her apartment during the interview, demanding money and alcohol. Irma is, understandably, greatly disturbed by her son's behaviour. She lives alone in a small apartment. Irma is one of the few persons who speak better German than Russian, and the interview was carried out in both languages.

Irma was recruited with Emma's assistance (snowball effect).

8. Ekaterina (56) and Kirill (58) Fritzsche

Russian German *Aussiedler*, arrived in Berlin from a mid-sized Ukrainian town with two children in 1993. Kirill has higher education in natural sciences, Ekaterina is a qualified

nurse. All adult family members (including sons) are steadily employed, with the exception of Ekaterina, who has MS, is unable to work and receives welfare compensation. The spouses live in Marzahn, however, were interviewed in the home of their daughter-in-law, a personal friend of the author. Given that Ekaterina has MS, and Kirill has chronic cardiovascular problems, the family has gathered significant experience with German medical care.

Ekaterina and Kirill were recruited by means of private networks.

9. Erwin (73) and Kristine (71) Kanz

Russian German *Spätaussiedler*, arrived from rural Kazakhstan. Non-qualified manual workers; Kristine is almost fully illiterate (can sign correspondence, but is unable to read or write it); Erwin knows how to read, but cannot write. Both spouses speak only German, in a rather strong Swabian dialect, typical for some groups of Russian Germans and difficult to comprehend. In Berlin since 1995; receive a pension. Have four children, all of whom live in Berlin in close vicinity. Other members of the extended family also live in Germany or in Berlin, having arrived recently. Erwin and Kristine occupy a two-room apartment. The spouses have not spoken of any long-term or chronic conditions in the family, although Erwin's heart attack was mentioned (but not discussed).

Erwin and Kristine were recruited through Albert and Nina (snowballing).

10. Tanja Klein and her mother, Aunt Ljuba (she introduced herself as Aunt NN).

Tanja and her mother arrived from rural Kazakhstan as members of the Russian German ethnic minority. Aunt Ljuba used to be a qualified clerk at the kolkhoz administration, Tanja has not finished her education as a hairdresser. The women live separately (Tanja has a family, her mother lives alone), but very close to each other and spend a lot of time together. In Berlin since 2002, both long-term unemployed and do not speak German. I met them while walking in a park in Marzahn. Hiding from the rain, they invited me to share a seat on a sheltered bench and offered me Chinese noodles with a sip of vodka, left from their own lunch. That was the only occasion I spoke to Aunt Ljuba. I have met Tanja later again and interviewed her in McDonalds next to her local Job Centre.

Experts:

1. Viktor Klett (37)

Viktor Klett is a psychiatrist focussing on problems specific to the treatment of Russian German *Aussiedler*. Himself Russian German, he moved to Berlin in 1992 as an *Aussiedler*, confirmed his diploma and started a counselling practice. At the end of the 1990s he defended a dissertation on 'Special Issues in Psychiatric Treatment of Russian German *Aussiedler*' in one of the most renown Russian Universities. Viktor's practice is well-known among migrants and is listed in all telephone books on 'Russian Berlin'. He is also well-known among other Russian-speaking doctors. His counselling room is located in his own private house.

2.Vadim Hochberg (43)

Vadim is a journalist and a writer with equal proficiency in Russian and German. As a Russian German, Vadim had been covering issues related to the problems of this ethnic minority in the Russian press, while he lived in one of the largest cities on the Far East of the country. Since arriving in Berlin in 1994, Vadim has started a Russian newspaper for Marzahn residents, organized a Russian literary society and drew funds to open an NGO consultancy for *Aussiedler* in Marzahn. Vadim is also actively involved in municipal politics, being responsible for migrant issues at the neighbourhood administration level.

3.Andrei Sokolov (32)

Andrei is a surgeon in a large hospital based in Marzahn. Along with his work in the hospital, he was also giving small seminars on health and consulting *Aussiedler* about access to healthcare services in an NGO started by Vadim. A great number of his patients are Russian Germans. Andrei belongs to the group of self-funded migrants: he arrived in Germany as a professional (in 2001), willing to increase his qualifications. He is fully employed and speaks fluent German.

4.Jonas Friedman (31)

Jonas works as an ambulance nurse, transporting ill persons to the Marzahn-based hospital where Andrei works. Himself 'local' German, he encounters Russian Germans in need of urgent medical help on a daily basis.

Jonas was recruited by means of an Internet announcement in a blogging community.

'Locals':

1.Stephan (37) and Marlene (39) Maier

Stephan and Marlene occupy an old spacious house on the edge of Marzahn. The house *is a legacy of Stephan's family, which lived in the GDR till mid-1980s until the family was able to flee to the West.* Many years later, having married Marlene, Stephan has managed to re-claim his property rights and get the house back.

Both spouses have higher education in technical sciences. Stephan runs his own engineering business; Marlene is employed with municipal engineering service. The couple have two children.

Stephan and Marlene were recruited by means of the blogging community.

2. Maike (61) and Wolfgang (65) Hauf

Maike and Wolfgang have lived in Marzahn since its foundation, and have never moved out. Both spouses were steadily employed until retirement age and were able to keep their semi-qualified engineering jobs after re-unification. At the moment both spouses receive pensions.

Maike and Wolfgang were recruited by means of academic networks.

3. Jens Wittkopf (52)

A patient of Andrei Sokolov, Jens is a former GDR citizen, who fled the GDR in the 1970s and returned back to 'his' Marzahn after re-unification. Jens, in his own words, has an alcohol problem, 'because he spends too much time with Russians'. Jens is officially unemployed, however, he is involved in a semi-legal business of selling cars in the former USSR.

4. Katrin Voigt

Katrin is Jens's neighbour, a single woman in her sixties who has lived in Marzahn since the neighbourhood was established. Katrin was one of the first people I spoke to, and given her very strong Berlin dialect, I had difficulties interviewing her. Our conversation was quite short, and I failed to follow-up a few themes she mentioned, because I did not understand her (as became apparent later from listening to an audio file).

II. Charlottenburg

1. Eva Lemke (75)

Russian German *Aussiedler*, arrived from Moscow. Has higher education and an academic degree. Speaks very fluent German. In Berlin since 1997. Receives a pension and occupies a council apartment. Eva lives alone and has no close relatives in Berlin.

Eva was recruited with the assistance of a Russian grocery shop owner in Charlottenburg.

2. Inna Kantorovich (52)

Jewish *Kontingentflüchtlinge*, arrived from a mid-sized Ukrainian town in 1994. Has higher education in natural sciences. Is self-employed: Inna runs a small second-hand shop in Charlottenburg. Is married and has one adult son living separately. Her husband is unemployed and helps her in the shop. The couple occupies a council flat on the less attractive end of Charlottenburg.

Inna was recruited incidentally: the author bought a pair of lovely shoes from her, and while paying recognised her Russian accent.

3. Irina Schmidt (27)

Russian German *Aussiedler*, arrived from a mid-size town in Kazakhstan as a teenager in 1994. Graduated from a Gymnasium (the highest level of school education) and at the time of interview was studying in the University for an MA in economics. Works as a waitress in one of the most famous Russian restaurants in Berlin. Occupies a flat in an *Altbau* in central Charlottenburg, which she shares with her Jewish boyfriend.

Irina was recruited with an assistance of the restaurant owner.

4. Paul Altman (53)

Jewish, self-funded. Paul arrived to Germany in 1988 as a tourist with an intention to remain by all means. First, he stayed in the country as an undocumented migrant and ran a semi-legal gambling machine business. Once the *Kontingentflüchtlinge* legislation came into force, Paul legalised himself as a quota Jew, started his own grocery business and brought his family (mother, wife and two children) into the country. Paul occupies an *Altbau* apartment in one of the most picturesque and expensive parts of Charlottenburg.

Paul was recruited with the assistance of a Russian grocery shop owner in Charlottenburg.

5. Mischa Gurevitsch (48)

Jewish, self-funded. Misha left a big city in one of the Baltic republics of the former USSR for Israel in the early 1970s together with his parents. However, given their mixed Jewish/German descent, the family was soon able to migrate from Israel to West Berlin, where they have been living since 1972. Misha is a steadily employed highly qualified dental technician. Misha is divorced, has one son and at the time of interview was single. Misha occupies an *Altbau* flat in a high-end residential area of Charlottenburg.

Misha was recruited at the Russian-speaking yoga course.

6. Sonja (36) and Boris (48) Perelman

Both Jewish, both self-funded. Sonja came to Berlin from Moscow in the early 1990s to study linguistics and graduated from a renowned German university in German Studies and received an academic degree equal to a PhD. She owns a fashion retail business which she runs with partners in Russia. Boris, an MD in dentistry, arrived in Berlin as a child in the early 1970s from Leningrad (Boris does not remember the exact year), with his family, similarly to Misha's making a stop in Israel in between. He studied dentistry in several West German medical schools and also improved his qualifications through training abroad. He runs a surgery he inherited from his father, a former high-ranking dental surgeon in the USSR and a well-established doctor in Germany.

Sonja and Boris were recruited with Misha's assistance (snowballing).

7. Julia (55) and Joseph (58) Markov

Jewish, *Kontingentflüchtlinge*. Have arrived from a big city in Moldova in 1997. Julia has a higher education; Joseph is a semi-qualified manual worker. Julia has a permanent clerical job in the Jewish Community House; her husband is long-term unemployed, receiving welfare benefits. The couple has two adult daughters; one of them being employed full-time, the other doing post-graduate studies. Both children live separately, but in close vicinity. The couple occupies a council housing apartment in central Charlottenburg.

Julia and Joseph were recruited with assistance of their daughter, who is a research colleague of the author (academic networks).

8. Oleg (36) and Lisa (34) Borisenko

Russian, self-funded/West German. Oleg arrived from a big city in Belarus to join his German girlfriend in 2001. They are now married and have two children. Oleg is a professional musician, qualified as a music therapist in Germany. Lisa is a doctor. Both

spouses are fully employed and occupy a big *Altbau* apartment in the very centre of Charlottenburg. The couple participates in various development aid projects in Eastern Europe.

Oleg and Lisa were recruited with the assistance of Stephan and Marlene Meier (snowballing).

9. Tamara (78) and Grisha (82) Rosenstein

Jewish, *Kontingentflüchtlinge*. Arrived from Moscow in 1995 to follow their son who moved to the GDR as a member of the Soviet diplomatic mission in the mid-1980s and decided to stay in Berlin after re-unification; receive a pension. Both spouses have higher education. Tamara and Grisha occupy a council apartment in the less attractive end of Charlottenburg, their house being mostly populated by migrant families from ex-USSR and Turkey.

Tamara and Grisha were recruited with the assistance of a personal friend.

10. Natasha Petrova (39)

Russian, self-funded. Natasha has come to Berlin in the late 1988. Back then, being married to a Jewish man, she persuaded him and his family to apply for permission to leave for Israel and subsequently moved to West Germany. Having migrated as part of this extended Jewish family, Natasha, however, soon divorced her first husband, and found a German partner with whom she had her second child. Natasha lives with her boyfriend and children in a Charlottenburg *Altbau*. She is fully employed as a dental technician (a profession she was trained for in Russia) and works with Boris and Misha.

Natasha was recruited with Misha's assistance (snowballing).

11. Bella Rabinovich (76)

Jewish, *Kontingentflüchtlinge*. Arrived from Moscow in 1992 to follow her son, a self-funded migrant who had settled in Berlin a few years earlier, started a business and brought his family in a few years later. As a young girl Bella survived the Holocaust and managed to flee from a concentration camp in the Ukraine. She has a higher education and is very active in the Jewish Community. As a professional ergotherapist with many years of experience, Bella volunteers in the Jewish nursing home to organize different activities and cultural programme for its patients.

Bella was recruited through the Jewish Community.

12. Lena Zimmerman (37)

Jewish, self-funded. Lena has come to Berlin from Leningrad in 1991 to join her German boyfriend, who helped her enrol at University and shared a flat with her. By the end of the 1990s she graduated, the couple got married and had their first child. Lena's parents joined them soon, her mother being in urgent need of medical treatment unavailable in Russia. At the moment, Lena's husband is posted to Moscow as a high-ranking investment banker, and Lena lives between Moscow and Berlin, spending half of her time with her parents, and the other half with her husband. Her children study in both countries. Lena is not employed, but being very artistic spends a lot of time painting and doing sculpture. Lena's apartment, now occupied by her parents, is an a Neubau very close to Charlottenburg main station.

Lena was found through blogging communities.

'Locals':

1. Stephanie Block (34):

Stephanie is the daughter of dissident GDR doctors who fled East Berlin in the early 1980s. An MD herself, she works in Berlin University Clinic, the Charite. Her partner is also a doctor in the same hospital. At the time of interview they were expecting their first child to be born. The couple occupies a large newly renovated flat in the most upper-class end of Charlottenburg.

Stephanie was recruited with the assistance of a personal friend (a doctor colleague).

2. Monica (32) and Holger (34) Grünwald

Both spouses are West Germans who moved to Berlin during while students. Monica and Holger have 3 year old twins and occupy a very large apartment in the very middle of Charlottenburg. Monica has a postgraduate degree in sociology and is fully employed in one of the Berlin research institutes. Holger runs a small business selling deli spice and oil. The couple actively supports various development aid programmes.

Monica and Holger were contacted with the assistance of Oleg and Lisa (snowballing).

3. Nicole (55) and Eric (61) Zeiler

Nicole and Eric moved to Berlin in 2005 from a small town in one of the Southern federal lands, where Eric used to chair the local administration. At the time of interview he was on

a sabbatical writing a book, and Nicole held a full-time managerial position in the Job Centre (state-run employment office). They occupy a large flat in the Altbau in one of the most picturesque parts of Charlottenburg.

Nicole and Eric were contacted with the assistance of another Russian-speaking Job Centre employee, who was initially meant to be interviewed as an expert, but changed her mind, offering another contact as a 'courtesy' instead.

4. Jürgen Teppich (95)

Jürgen was the only German member of the Jewish Community I managed to talk to, however, our conversation was not very fruitful, because of his strong dialect. Our conversation took place during one the Senior Members Tea Meetings and lasted for half an hour. I was introduced to Jürgen by Bella.

Experts:

1. Karina Goldmann (34), administrator of the Social Work Department of the Jewish Community.
2. Tatjana Lewina (57), head of the Social Work Department of the Jewish Community.

Karina was initially contacted by e-mail, and a date for a meeting was arranged. After talking to me, she suggested I contact Tatjana, the head of her Department who, Karina thought, could give me a few tips on how to approach Community members, and who, she believed, also needed to know about the purpose and the ethical standards of my work.

The Social Work Department both women work in is in charge of distributing of various material and non-material goods. It supervises the issue of material benefits and compensation, assists with all legal problems migrants may have with their status and organizes social work for members of the community in need. In particular, it runs a Jewish nursing home and supervises several ambulant nursing care stations.

III. Non-neighborhood-specific experts:

- Hartmut Weiss (58)
- Annette Klaus (47)

Both Hartmut and Annette are former GDR doctors who have studied and worked in the USSR and speak fluent Russian. Hartmut is a GP and Annette is an internist with a focus on liver diseases. Both have a very broad Russian-speaking clientele. They were contacted through the 'Russian Berlin' telephone book.

Appendix 2. Glossary

Altbau (Ger.) – An ‘old’ house (built before the second world war).

Ausländer (Ger.) – Foreigners

Aussiedler or Spätaussiedler (Ger.) – ‘Repatriate’ or ‘Late repatriate’, a legal status granted to members of Russian German ethnic minority group migrating from the former USSR into Germany

Blyad (Rus.) – A tabooed word meaning, literary, ‘slut’ or ‘whore’

Banya (Rus.) – A sauna with a steam room

Blat (Rus.) – Relationship of informal exchange sustained through private networks. Blat is often practised to gain access to institutional resources by private means.

Chuzhie (Rus.) – Strangers; those identified as not belonging to a group one identifies him- or herself with.

Gastarbeiter (Ger.) - German term for guest worker (a person with temporary permission to work in another country).

Gemeindehaus (Ger.) – Community House (in context of the Berlin Jewish Community)

Einheimische (Ger.) – Persons identified as native Germans

Hochdeutsch (Ger.) – ‘High’ German; the standard of the German language adopted as national.

Kolbasa (Rus.) – Sausage; in jargon may also stand for all things material (like in ‘All you can think of is kolbasa’ = You only care about material issues) and acquire a derogatory meaning.

Kolkhoz (Rus.) - a collective farm in the former USSR

Kontingentflüchtlinge (Ger.) – ‘Special refugees’, a legal status granted to Jews from the former USSR in Germany.

Kulebyaka (Rus.) – A traditional Russian meat pie

Kul’turnost (Rus.) – Being cultured (the detailed definition of this term is given at page 93)

Kul’turnie ludi (Rus.) – Cultured people

Leitkultur (Ger.) – Leading culture.

Macaroni po-flotski (Rus.) – Noodles with fried mince

Menschen mit Migrationshintergrund' (Ger.) – Persons with migrant background

Multi-Kulti (Ger.) – Multiculturalism

Neubau (Ger.) – A 'new' house (built after the second world war)

Pelmeni (Rus.) – A type of Russian pasta filled with mince, resembling Italian ravioli

Spätaussiedler (Ger.) – see Aussiedler

Svoi (Rus.) – 'Our people'; those identified as belonging to a group one identifies him or herself with.

Takaya zhis'n (Rus.) – Life as it is; the most direct translation would be 'that is how life is'. A more detailed discussion and definition of this concept is given at page 92-93.

Valenki (Rus.)– Felt shoes

Völkisches Nation (Ger.) – Folk nation; a nation composed of one folk, with nationhood determined by ethnic descent or the 'law of blood'.

Volkszugehörigkeit – Belonging to the German folk by ethnic descent.